VOLUME 16

THE CHILD

AUGUST–SEPTEMBER 1951

to JUNE–JULY 1952

FEDERAL SECURITY AGENCY Social Security Administration • Children's Bureau

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U. S. GOVERNMENT PRINTING OFFICE: 1952

THE CHILD

AUGUST-SEPTEMBER
1951

KATHARINE F. LENROOT RETIRES FROM THE CHILDREN'S BUREAU

Martha M. Eliot, M.D., Succeeds Her

AT HER REQUEST, President Harry S. Truman has accepted Miss Lenroot's resignation as Chief of the Children's Bureau, to take effect on August 31, 1951.

In retiring from this position, Miss Lenroot says she needs some leisure, some time to read and to use for activities that have been crowded out of days dedicated to making this Bureau an effective instrument of the people for serving children. No one can begrudge her the leisure she has so rightly earned. But the Bureau staff, and thousands of other people who have worked with her, will miss the inspiring guidance and tireless help that she has given them for so many years, ever since she joined the Bureau staff in 1915, became Assistant to the Chief in 1922, and especially during the 17 years she has been Chief.

Many honors have come Miss Lenroot's way and many responsibilities have been laid on her during her 36 years with the Bureau. She was President of the National Conference of Social Work in 1935; Chairman of the U. S. Delegation to the 5th, 6th, and 9th Pan American Child Congresses; President of the Eighth Pan American Child Congress; U. S. Representative on the Advisory Committee on Social Questions of the League of Nations; Adviser to the U. S. Government delegates to the International Labor Organization Conference in 1945; Adviser to the U. S. Delegation to the Inter-American Conference on Problems of War and Peace in 1945; U. S. Member of the Executive Board of the United Nations International Children's Emergency Fund since 1947. Holder of the Rosenberger Medal from the University of Chicago, the Gold Medal of the National Institute of Social Sciences, and the Survey and other Awards, she has been awarded honorary doctoral degrees by Wisconsin, Tulane, and Western Reserve Universities and from Russell Sage College.

The Children's Bureau staff salutes a valiant and devoted spokesman for children here and around the world, and welcomes as her successor our long-time friend and former Associate Chief, Dr. Martha M. Eliot, whose nomination by the President was confirmed by the U. S. Senate on July 24, 1951.

June 22, 1951

Dear Mr. President:

I hereby request retirement from the Federal service as Chief of the Children's Bureau, effective September 1 or as soon thereafter as arrangements can be made for my successor to take office.

It is, indeed, a hard decision to make to leave the Children's Bureau, with which I have been associated throughout almost my entire working life. In the 36 years in which I have been a member of the staff, great advances have been made in maternal and child health, child welfare, and child-labor protection. The Bureau has played a significant part in these changes through research, dissemination of information, cooperation with the States in grants-in-aid, establishment of Federal child-labor standards, and development of methods of cooperation with citizens in behalf of children. It has shared with other nations knowledge and experience relating to child life. The Midcentury White House Conference on Children and Youth served to broaden our understanding both of the importance of going forward in extending and improving services to children, especially in this critical period of world history, and of the need for much more extensive research. I am grateful, especially, for your sponsorship of the conference and the great contribution you made to its success.

In laying down my task, because I have reached the age when I must have more leisure, I am confident that with your understanding and support of its program, the Children's Bureau, with its broad concern for children and youth, will be given still greater opportunity to serve our country and the children who are its future.

Respectfully yours,

Katharine F. Lenroot

July 9, 1951

Dear Miss Lenroot:

With real regret I accept your resignation as Chief of the Children's Bureau of the Federal Security Agency effective at the close of business on August thirty-first next.

You have been in Government service for 36 years, and for the past 17 years you have headed the Children's Bureau. That is a long tenure of office for any public servant. But it is especially significant because you have been one of that small and select group of women who have risen to high public office through merit and determination. Best of all your service has been as distinguished as it has been long-continued.

Toughness is a quality not often attributed to women but the plain fact is that you have been a tough and persistent champion of America's children. You have made them both your vocation and your avocation. The children of this country are better off for your having been in the Government. What greater satisfaction could anyone take into retirement?

Although you will soon retire to a well-earned rest, I hope that from time to time I shall have the chance to look to you for advice and help in matters affecting the children of America. I know that you will never relinquish your interest in their welfare as long as you live.

With warmest good wishes, I am

Very sincerely yours,

Harry Truman

RHEUMATIC FEVER AND THE CHILD'S EMOTIONS

BETTY HUSE, M. D.

Every child has his own worries, and the child with rheumatic fever has plenty of them.

RHEUMATIC FEVER, like any other serious or long-drawn-out illness, is sure to have some effect on a child's emotional development. It affects this development differently in different children. What it does to a child depends on what his experience with the illness means to that particular child.

Of course, the child's experience with rheumatic fever will depend partly on how severe his attack is, what his symptoms are, how long he is sick, and what methods of treatment are used. Rheumatic fever may attack the child's joints, his nervous system, his skin, or his heart. The severity of the disease varies, too. One child may have a high fever and painfully swollen joints. Another may have pains in the joints so mild that he goes about his usual activities without realizing that he is sick. The child is usually sick with rheumatic fever for a long time—often for many months.

What is his emotional background?

But the child's experience will depend in large part on what kind of child he is and on what has happened to him in the past. It will depend on the kind of body and mind he was born with; on how old he is when he gets rheumatic fever; on his relationships with his father and mother; on how he gets along with his brothers and sisters and other children; on his previous experiences, good and bad; and on his general pattern of coping with his problems. And, because a child is so much influenced by his parents, it will depend too on how the parents feel about the disease.

What are some of the factors in rheumatic fever that are likely to affect the emotional development of a child who is attacked by this disease?

Since few children under the age of 3 years get rheumatic fever, we must realize that as a rule the child who does get it has already developed some of his fundamental emotional structure. But much of his development is still to come, and the disease may retard or distort it.

Death is a real possibility in rheumatic fever, either early in the acute stage, or at some future time if the disease gets worse. A young child may not have a clear idea of this, but he may reflect the fear shown by his father and mother. Older children more often than we imagine become aware of this possibility through what they overhear and guess, and they may be very frightened. A frightened child may even convince himself that he is not sick and refuse to do the things that would help him get better.

A sick child, like any other sick person, tends to go back, at least temporarily, to his earlier ways of behaving. Some of the child's earlier patterns of behavior, such as bed-wetting, thumb-sucking, babyish eating habits, and depending too much on his mother, may worry his parents. And often the more the parents worry, the more babyish the child gets. If his babyhood or early childhood gave him more satisfaction than his present time of life, or if he had problems earlier in life that were never quite solved, it may be hard for him to get back to acting his age. Sometimes, on the other hand, a successful encounter with

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Dr. Huse is Pediatric Specialist in the Program Planning Branch of the Division of Health Services, Children's Bureau. She is a pediatrician who has spent a good portion of her professional life working on the problems of rheumatic fever. Among her jobs in the Children's Bureau has been consultation to the States on programs for the care of children with this disease.

This article is based by Dr. Huse on a paper that she prepared for the Midcentury White House Conference on Children and Youth. The paper is one of a number that served as resource material for the Fact Finding Report of the Midcentury White House Conference on Children and Youth, which is to be published in the fall of 1951. The procedures of the conference did not provide for official approval of these papers. Address inquiries to National Midcentury Committee for Children and Youth, FSA Building North, Fourth and Independence Avenue, S. W., Washington 25, D. C.

an illness seems to lead to a real spurt in emotional development.

Often a child does not understand the real purpose of a medical procedure, and attributes to it a purpose that is connected with his own imagination and inner life rather than with reality. Blood transfusions, blood-pressure recording, needles, taking of rectal temperatures, oxygen tents, X-rays, fluoroscopes, and so forth, may be interpreted in bizarre ways. The child may think that people really want to injure him, or that he has earned this treatment as punishment.

In the early stage of the disease the child is almost completely dependent on his mother or a nurse. He is fed, put on a bedpan, given a bath in bed, lifted from one position to another. This physical dependency may be unwelcome to some children, welcome to others. One child may deal with it by outright rebellion; another may enjoy it and not want to give it up.

Often a child with rheumatic fever must be taken from his home to a hospital or a convalescent home. Separation from the parents may be a great shock for the preschool child, and the effect of this shock may seriously interfere with his ability to form emotional relationships with people later in life. It is usually less serious for the child from about 6 years to the beginning of adolescence, but may still be very hard for some children. For an adolescent, separation rom his parents may stir up latent emotional conflicts having to do with the adolescent's attempt to become more independent of his parents.

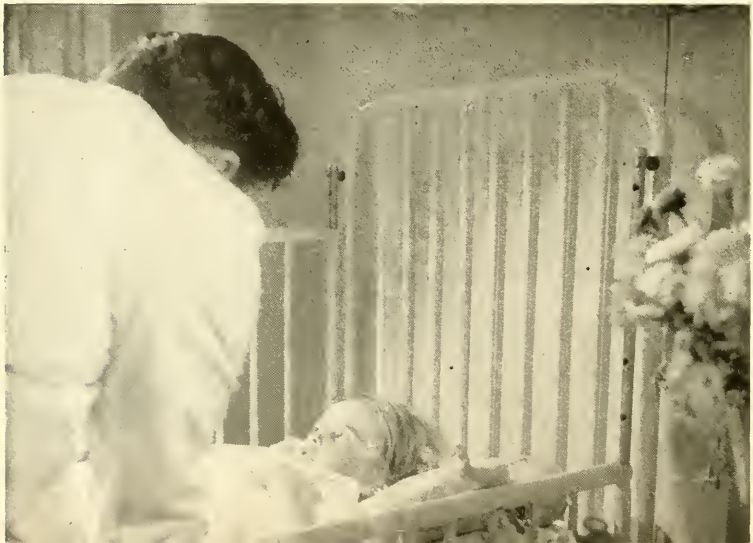
The child with rheumatic fever may at some point in his treatment be separated from other children of his own age. If this separation lasts a long time, as it may, the school-age child may be slowed up in developing relationships with other youngsters of his age. The adolescent may suffer acutely since he depends so much on others of his own age in his struggle for independence, for recognition as an adult man or woman, and for a firm set of values for himself.

When a little child, 3 to 6 years of age, is obliged to stay quiet in bed, he is kept from his natural ways of blowing off steam.

For the older child such restriction keeps him from playing with his friends. And it may mean interference with types of play that are important to his emotional development. It may also mean interference with schooling, which is so important as a way of learning to understand and deal with reality. It may interfere with creative activities, such as art and music, and thus interfere with a good method of dealing with emotional problems.

It is true that the heart is generally affected in rheumatic fever, and that actual infection of the heart may cause heart failure and even death during an acute attack. However, the scarring of the heart known as rheumatic heart disease, which may remain after the acute attack has passed, should not as a rule interfere with the child's life, though an occasional child is left with handicapping heart disease. Even though fear of handicapping heart disease is usually unfounded, many parents, and even the children themselves, are worried and afraid about the future. A young child may reflect his parents' fears, but an older child or an adolescent may himself be frightened about what may happen to him. The adolescent may have real worries about the possible effect of his heart disease on his prospects for earning his living and for marriage and having children.

This little girl, with an attack of rheumatic fever, had to go to the hospital for treatment. At this age, separation from her mother and father is likely to be a great shock to her.



Mother and father worry, too

The reaction of the mother and father to the illness of their child may be very complex. There will usually be real fear; there may also be anxiety related to the parents' own emotional reactions to the idea of illness and possible death. The parents may feel guilty for a variety of reasons. They may blame themselves on the ground that the child may have inherited the disease; or they may feel that they have given the child inadequate care before the illness. (Either of these ideas may have been suggested to them by neighbors or by something they have read.) Or they may without knowing it blame themselves for hostile thoughts they have had about the child from time to time or for past deeds they have on their conscience.

At the beginning of the illness the mother will usually throw herself into the care of the child at a pitch that she cannot possibly keep up as the disease drags on. The dependency of the child and the needs for restricting his activity may be welcome to the parents, or it may be almost unbearable to them. The time and attention that the mother gives the child, and her attitude to-

(Continued on page 11)

TO STRENGTHEN MATERNITY-HOME SERVICE FOR UNMARRIED MOTHERS

JANE E. WRIEDEN

DURING the long history of maternity homes for unmarried mothers, such homes have on the whole progressed greatly in both policies and practices. But not all the homes have changed enough to meet modern standards. And even the best of them could further improve their services.

Improving this form of social service is a complicated task. The homes need the skills of the obstetrician, the pediatrician, the psychiatrist, the nurse, the case worker, the group worker, and the psychologist. This is because the problems in a maternity home usually have grown out of a young woman's confused relations with other people, her lack of understanding of herself, and her immediate need of medical and nursing care in a sympathetic atmosphere. The lifelong health and happiness of the mother and child are the aim of the service. Whatever is best for each one of them is planned for and worked toward; in the process all phases of life may be touched on.

Homes and agencies supply facts

As a step toward finding out how far we have progressed in improving these homes and how much we still have to accomplish in making them as useful as possible to unmarried mothers and their babies, I asked some questions across the country about the services. I sent out 235 letters in January 1951, to a number of maternity homes and to a family agency and a children's agency in each State. (All of the social agencies were members of either the Family Service Association or the Child Welfare League of America.) Thirty-two of the maternity homes and 63 of the social agencies sent me the needed information. I also studied the standards that several States have established for licensing and supervising maternity homes. I talked with a number of unmarried mothers to get their opinions on how homes could be improved. As a result, I find that I can generalize as follows:

1. All who work with unmarried mothers are much more aware than before of the complexity of the problems these mothers must solve. All are anxious to raise the standard of services available to her for herself and her child, especially the standards of maternity homes.

2. Maternity-home service has developed unevenly in different parts of the country, in cities large enough to have several homes, in agencies operating a network of homes located in different States, and in agencies operating several homes in the same State.

3. The essentials of good maternity-home service, all of us agree, are: A good staff capable of giving case work, group work, medical and nursing service; housing and other facilities that are adequate; and funds that are sufficient. But we differ on three points: What is meant by "good," "sufficient," "adequate"; what constitutes case work, group work, and the right amount of nursing care; and *how* to achieve our objectives.

4. Not all homes have policies based on today's knowledge. We need more study in order to decide what our aims are and to clarify our methods of work. Besides the gaps that are apparent in what we know there are gaps between what we know and what we do.

5. Our maternity homes are not reaching all unmarried mothers who could use the service to advantage. We have not even scratched the surface of our task of building a public-information program that will get information to all the girls who need us and that will carry the interest of the civic-minded people of a city along with our work.

6. A national code would be valuable, a statement of the principles underlying maternity-home service, from which each home could develop sound policies and practices suitable to its own work.

If we are to accomplish the changes indicated by these six points, we have to begin somewhere. This beginning is what we are considering here.

A sound philosophy and clear, definite policies should result in practices of high quality. If the service of a maternity home grows out of concern for the well-being of an individual, based on respect for the dignity and worth of all individuals; if we are committed to democratic ideals and practices; and if we recognize the primacy of spiritual values, then we have a sound philosophy. Our practices will reflect this acceptance of individuals as they are, our wanting to understand their problems and to be permissive and flexible in dealing with them; our keeping their confidences inviolate; and our giving them freedom within broad limits that are acceptable to them.

The maternity home is a home even though a temporary one; its

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Jane E. Wrieden, a major in The Salvation Army, has been on the Army's staff for over two decades. In order to get graduate education in social work, Major Wrieden took time off from her duties. She gained her degree from the School of Social Work of the University of Buffalo. She has been director of the Salvation Army Home and Hospital, in Jersey City, N. J., a home for unmarried mothers, for 4½ years.

This article is based on a paper that Major Wrieden gave at a meeting of the National Committee on Service to Unmarried Parents, which was held in association with the seventy-eighth annual meeting of the National Conference of Social Work, convened at Atlantic City, N. J.

setting should be as normal as possible. Any policy that imposes restrictive living conditions, or that implies that a resident does not have freedom of decision in the home is indefensible.

A place for self-discovery

We should examine what we mean by some words we use frequently, such as "secrecy," "seclusion," "protection," to decide whether the practices implied are in harmony with our philosophy of today. The maternity home should not be, as it was in its early history, merely a haven, a refuge, or a place of escape, though it does offer privacy and confidential services. It is a place for helping an individual rather than a place for overprotecting her, patronizing her, or punishing her. It is a place where love and freedom can be given to the residents but in a way to spur an appreciation of their personal responsibilities and of the rights of others. It is a place for self-discovery, not for indoctrination, a place where the person and the group may grow in insight through helpful experience. The treatment given takes into consideration everything that has happened to the girl, not only her pregnancy outside of marriage, which may well be a symptom of something deeper. The treatment is to meet whatever needs the individual has—the emotional, physical, economic, educational, recreational, or spiritual needs.

This philosophy will be effective only if our practices are flexible. We must be open-minded about such points as these: The time during pregnancy that we admit an applicant and the length of her stay; the whole question of fees; persons to whom the service is offered (for example, to a woman who has some physical ailment such as a venereal infection or epilepsy, or to a married woman who is illegitimately pregnant, or to a woman who has been pregnant before). Our practices must be flexible in regard to the mother's decision about whether or not to see her baby after his birth if he is to be placed for adoption; about whether or not to feed him at the breast; about group activities; about a resident's attendance at religious services; about her visiting in or outside the maternity home, as well as about house routines in general. Rigidity of practice has no place in services to human beings. Frequent review and revision of policies and practices as a result of staff experience should lead to the needed flexibility.

The lifelong well-being of both mother and child is the aim of good maternity-home service.

But flexibility must fit into the framework of reality—the reality of the resident's rights, the group's rights, the home's limitations, and the community's limitations. However, let us be careful not to use these realities and limitations as convenient pegs on which to hang our own unresolved conflicts, such as whether or not to give service to Negro girls who would benefit from maternity-home care. We should remember that courage to lead a community to rid itself of a limitation that denies rights to some of its people is part of the tradition of our field of work.

Good policies and practices decided upon can be carried out in the home only if good case work, group work, and nursing care are available. A spot check was made last year in one State by a committee of social workers to see what maternity-home policies and practices were in use. The check disclosed that although maternity-home service had improved to a certain extent in that State, there were still wide gaps between philosophy and practice; that some service was "rigidly religious," and focused on controlling rather than helping the resident; that some required the mother to stay as long as 6 months after the birth of her baby. Some homes, the report stated, could give better services, especially at the time of the mother's separation from her baby and in the period after her discharge from the home.

This illustration of the result of insufficient help was given: A girl of 18, who had decided to relinquish her baby for adoption, was required by the maternity home to keep him with her for 3 months before their separation. Although caring for him made giving him up very difficult, the mother did not receive the help she needed for herself in order to feel sure that she had made the best decision about her baby. She went ahead with the adoption; but 7 years later, when she was about to marry, she seemed

to show the results of this lack of help. She rented a safe deposit box for the sole purpose of keeping a picture of her baby where no else could see it, and went to the box every 2 weeks to look at the picture. If she had had the right kind of help early and if this help had continued as long as she needed it, she might have been spared this emotional conflict about having given up her baby.

If a maternity home intends to fulfill all the needs of an unmarried mother—emotional, physical, educational, and spiritual needs—and is without social case work, this lack is as illogical as if it had no nursing care. It is my firm belief that the case worker in a maternity home should not only have had full graduate education in an accredited school of social work, but should also have had experience in a case-work agency of high standards, before she joins the staff of the maternity home. Unfortunately, these homes, even today, tend to permit a person who lacks professional education and experience to act as a case worker and to expect her to do a professional job.

Case work is the core of help

Social case work is not something to be tacked onto a program. It is the heart of the maternity-home experience. This experience begins when a young woman first reaches out for help by means of a letter, a telephone call, or a visit to the home. The importance of what happens to her in the early stages of application cannot be stressed too much. Even the kind of stationery we use (plain, informal), the friendly tone of our letters, how promptly and graciously we answer the telephone —all these mean much to the applicant. This asking for help arouses deep feelings, perhaps of guilt and unworthiness, or of fear that help will be refused. Some girls tell us, "I'd been trying *so long* to find a place to go." For many girls—especially Negroes—this experience of seeking help is extra difficult—they have so far been unable to find a maternity home "that will take a colored girl."

In this early stage, the case worker helps the applicant to learn about the various services available; that is, what the alternatives are, what group living consists of, what she can expect of the maternity home, and what the maternity home will expect of her. Through this early contact and through close relations that follow, through what the case worker accomplishes for the young woman with other members of the staff and with her family and others concerned, the case worker helps the client get into focus the picture of what has happened. The worker can make psychiatric and psychologic help available as the worker and the girl continue their contact through the girl's period of adjustment to the group in the home, of her waiting for the baby, of his birth, of deciding about his future, of the separation from him if the mother decides the baby should be adopted. The worker helps the girl when she is leaving the maternity home and is returning to her normal pursuits. The help continues until the time when the client no longer needs the case worker's assistance.

How can a maternity-home administrator feel competent to help a young woman successfully through such an experience without having the services of a qualified social case worker? To that question my own answer is simple. I, for one, would not.

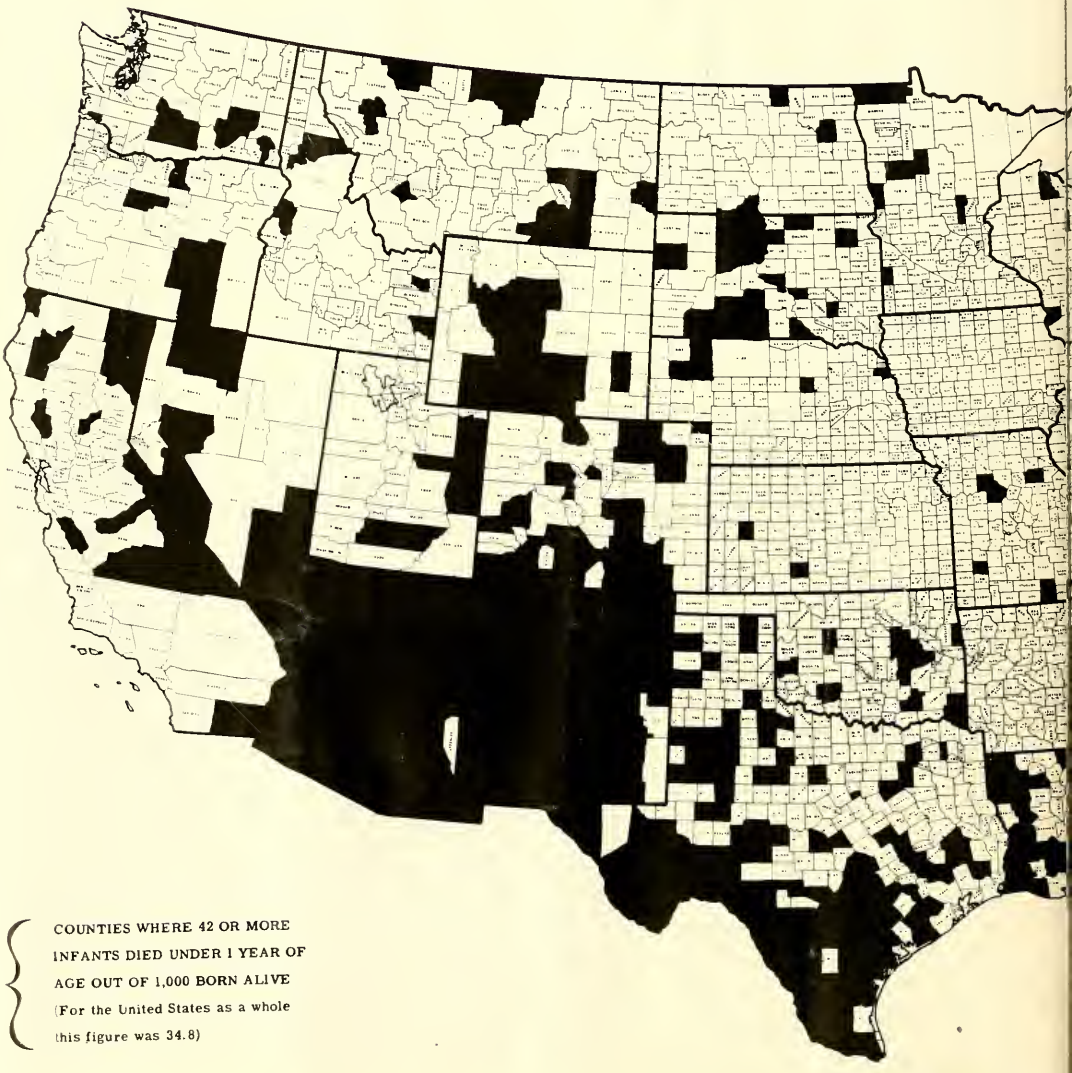
The help that these specialized services can give is illustrated by what they did for Miss Z, one of the many young women I have worked with in a maternity home. As she later put it, she came in with a chip on her shoulder and with two strikes against her—"I'm pregnant and I'm colored." She was polite but hostile, always ready for a showdown. But Miss Z got a great deal from her experience in the home. She was helped by her regular interviews with the case worker and by the conferences the worker had with other staff members to help them understand the meaning of the girl's behavior, and by a psychological evaluation of her aptitudes. She had decided to give the baby up for adoption, and so the worker arranged for her to go to an adoption agency. Afterward, with deep feeling, she told the case worker at

(Continued on page 11)

A well-run maternity home will provide health supervision, at the home or elsewhere.

THERE'S A BIG JOB STILL TO

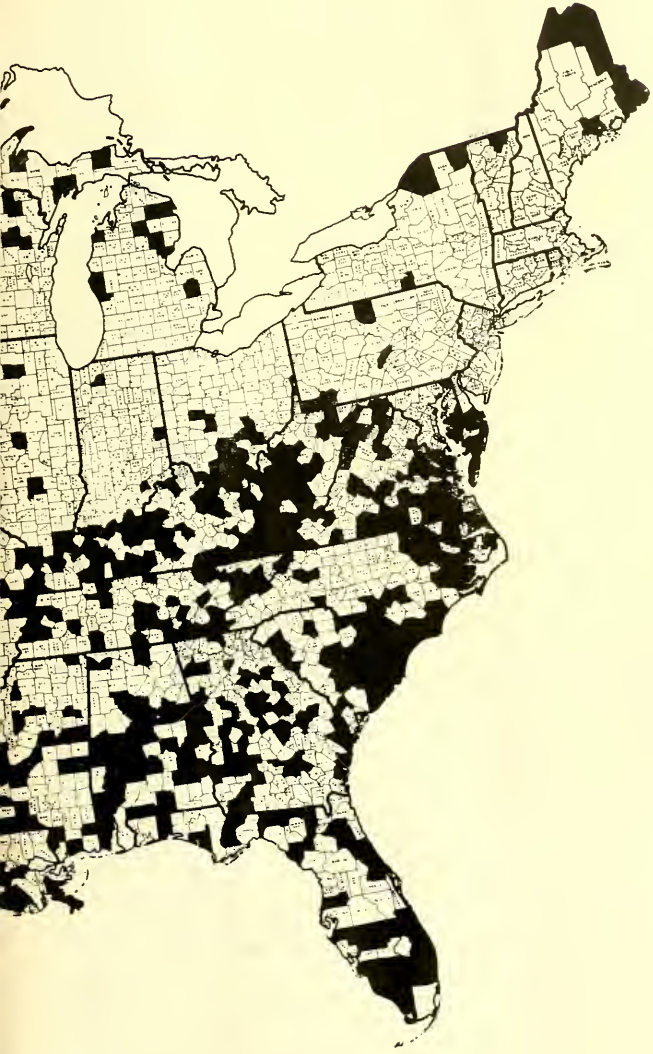
THESE U. S. COUNTIES HAVE THE HIGHEST INFA



COUNTIES WHERE 42 OR MORE INFANTS DIED UNDER 1 YEAR OF AGE OUT OF 1,000 BORN ALIVE (For the United States as a whole this figure was 34.8)

DO TO SAVE INFANT LIVES

NT MORTALITY RATES — 1944-48



In the United States as a whole the mortality rate among babies less than a year old has been going down for three and a half decades—from 100 deaths per thousand live births in 1915 to 29 per thousand in 1950 (provisional figure).

But many localities of the country still have high rates. The map on the left shows that nearly a quarter of our counties had an infant mortality rate of 42 or more during the 5-year period 1944-48, the latest 5-year period for which we have final figures for counties. Many of the shaded counties on the map join to form regional patterns, or high infant mortality rate areas, cutting across State lines.

If, in 1944–48, these counties had as low an infant mortality rate as the United States as a whole, the lives of about 40,000 babies would have been saved during those 5 years.

The problems connected with saving babies' lives are more than medical. They involve low incomes, poor sanitation, and habits of people. Often the area of high infant mortality is chiefly rural, and the people affected may be minority groups such as Indians, Negroes, or Spanish-speaking Americans.

These people need more doctors, nurses, nutritionists, and medical social workers, who know the special problems of these minority groups and can work effectively with them. They need, too, help in getting better sanitation and other health safeguards.

They need, most of all, a comprehensive attack on the problem, with Federal, State, and local governments and voluntary agencies cooperating in the work.

NURSERY SCHOOL CAN HELP CHILD'S SPIRITUAL GROWTH

RUTH TAYLOR STONE

HOW CAN WE lay foundations within the understanding of little children—3, 4, or 5 years of age—for spiritual growth, for faith in God as God comes to have meaning to them, and for joyous fellowship with others?

This is the type of earnest question that was discussed by a group of Sunday School teachers and directors of religious education in a 6-week evening extension course last winter at Boston.

The course was sponsored by several New England denominational groups and was led by a representative of the Nursery Training School of Boston. Fifty teachers from Boston and its suburbs brought their problems, many of which seemed difficult at first, but which proved, as the meetings progressed, in not a single case impossible to solve.

Problems of space and equipment, of how to teach, of how small children learn, of how to interpret a religious program to parents and officials led the members of the group to visit carefully selected weekday nursery schools and kindergartens.

Spiritual awakening comes early

They found that these children were learning the first principles of religion as they played with their friends, under wise guidance, gathered in small groups for a short story, or as they felt the soft petals of early spring forsythia, which had been unfolding day by day before their eyes.

For better teaching of religion we need to know more about child development, the teachers agreed. The little child must be given a setting in which he can be himself and learn at his own level. He needs space to move about freely, and he needs familiar play materials to experiment with and to share with his friends. He is full of the excitement of growing, is fascinated with learning all sorts of things, and is eager to learn; but he must learn in his own way.

The group realized that it is only too easy for a teacher of young children to try to teach religion without realizing the subtle ways in which the concept of God and of our share in God's world is developing in the child. The bursting buds in the springtime and the changing colors of leaves in the fall, the snow crystals under the magnifying glass —even a very young child can be helped to see that here is a power far beyond that of the heretofore all-powerful parent. These, the group felt, are worship experiences at the child's level; and from them will grow a concept of a divine being present in all life, in all activity, in all creativity.

The energy that makes it impossible for a 5-year-old to sit still and memorize a psalm can be used to make a bird-feeding station so that a fellow creature will live through a long winter, the teachers were reminded. Children learn with their whole selves. They can learn, and enjoy learning, principles of right and wrong. They can understand the behavior of the good Samaritan and imitate it, even though they may not yet be verbal enough to cope with formal prayers. The teacher needs to be alert to simple worship experiences that develop naturally as the children live and play together. And a good teacher knows that a long period of sitting quietly in a large group and being taught is unnatural to the little child. That is not his way of learning, and he will merely become bored and restless.

A good nursery school or kindergarten, it was agreed, endeavors to foster a friendly, cooperative atmosphere, in which children may grow into life with faith in themselves and their place in God's world. A good teacher not only finds sufficient space for active bodies and provides opportunities for wholesome play, with sturdy, well-chosen materials; she creates an atmosphere that is conducive to righteous living.

In such a class, the group agreed, strong and permanent foundations are laid for a child's religious growth.

Reprints in about 6 weeks

Observing the wonders of nature, little children can learn the first principles of religion.

Ruth Taylor Stone received her master's degree at Boston University School of Education. She is also a graduate of the Nursery Training School of Boston and is a member of its staff. She was for many years director of a private nursery school in a Boston suburb, and she devotes her spare time to parent education.

RHEUMATIC FEVER

(Continued from page 4)

ward him, may create conflicts between the parents.

All these reactions of the parents will be bound to affect the parent-child relationship one way or another, and thus may affect the child's emotional development profoundly, especially if the child is young.

As rheumatic fever affects each child in an individual way, so the method for dealing with the emotional effects of the disease must also be individualized, and based on understanding of the meaning of the experience to the individual child. The only thing that could help everyone would be a sure, fast cure of the disease.

Meanwhile, however, something can be done in relation to the child, his parents, and the personnel involved in treatment:

1. **For the child**—It is important that attention be given at every step to his potential emotional problems. It will help if the child is given an opportunity to talk about his fears and his angry feelings and to tell as much as he can about how he feels about his illness. Allowing him to take some active part in managing the situation is usually helpful. The small child may be given a chance to choose, for example, whether he gets his medicine straight or in applesauce, and to make similar decisions within the limits of the medical treatment that is required; an older child may be given some responsibility for more important decisions. Although the child may be expected to act younger than his age at the beginning of his illness he should be helped to return to more grown-up ways as soon as this is feasible, by encouraging him to take increasing responsibility. If he is restricted in his physical activity, the limits of these restrictions should be made very clear to him. He should be treated consistently. He should be prepared for new experinces insofar as possible by clear and true explanations. He should be given opportunities for play, schooling, and creative activities consistent with his physical condition, his age, and his interests. Separation of the child from his parents should be regarded as a serious step; and the decision to send a young child to a hospital or convalescent home should be made only if treatment in his home is impossible. An adolescent, on the other hand, may be able to get through his illness and convalescence better when he is cared for with a group of others of about his own age.

2. **For the parents**, too, much can be done. They should have opportunities for a careful and realistic discussion of the medical situation and the probable outcome of the illness. They should be encouraged to talk about their worries. They should be helped to see whether they are being unnecessarily indulgent or strict. And they should be helped to understand what their child is feeling and what he is worrying about, and how they can best give him support in this difficult situation.

3. **The personnel involved in the treatment of the child** can help greatly if they do their utmost to be consistent; if they can accept hostile or fearful attitudes on the part of the child or of his parents; if they consider every procedure in the light of the emotional as well as the physical effects and if they minimize emotional hazards by explaining the procedures to the child so far as is feasible, by eliminating unnecessary procedures, and by providing substitute outlets for his feelings when possible; if they watch the child's emotional condition in relation to his age and previous level of development; if they are as definite as possible about restrictions and drop them as soon as it is medically safe to do so; if they consider the child's emotional as well as his physical needs in planning for a period of separation from his parents; if they discuss his emotional problems with a psychiatric consultant and request consultation when this is needed.

Reprints in about 6 weeks

UNMARRIED MOTHERS

(Continued from page 7)

the home about her interview with the adoption worker; it was another step forward in the self-discovery she was going through in the maternity home.

Group work adds its therapy

All this (and much more of course) is what I mean by social case work—what I mean by saying that case work is the heart of the experience young women have in a good maternity home. In such a place a resident may know the graciousness of home life, the reality of spiritual values and of democratic ways; the richness of interfaith and interracial living. Some maternity homes have "residents' councils" in which the girls themselves discuss group living and set their own standards for it. How residents use the group experience depends partly on the stimulus they get. This does not mean a leader "doing for" the group, or volunteers from outside coming in to put on programs for the "in group." At its best, it means getting help from a professional group worker, who is, preferably, a member of the maternity-home staff, and who works with the group to help it make its recreational plans and to carry them out.

Small groups may be formed voluntarily for various recreational and craft activities. Girls may choose to make ceramics or hand-sewn gloves, to learn dressmaking, or work at oil painting. They may form camera clubs, gardening clubs, or discussion groups. In all the groups, the group worker should have the role of helper. Not all the activities are in the home. The young women, often in small groups, seek recreation outside — movies, concerts, walks, trips—maybe visits to the circus or to a museum. Some homes have found that their residents get a great deal from visiting cathedrals and other churches.

The work of a maternity home—housekeeping, maintenance, laun-

dry, and food services—is an important part of group living. Consider, for example, the contribution that nutritious, attractively served meals make to the well-being of residents and staff. Furthermore, it is necessary for the staff to understand what food can mean to a person psychologically; much has been learned in the psychiatric field about this. The question is often asked whether a resident should or shouldn't help with cooking and serving meals and the other work. That question should be, rather, whether the household tasks she does are helpful to her, taking their rightful place in the whole experience she has in the home.

In homes where religion is an inseparable part of the group life, groups may be formed for various kinds of devotions, but attendance should be by choice. Religion should not be something added to the program, but rather interwoven through all that is done. If it is, it is felt in the philosophy, the policies, the atmosphere of the home; in the relations between staff members, residents, and workers from other agencies to the extent that the clients may feel a deep faith, expressed in daily living.

For the health of all in the home

The health services in a maternity home should, of course, be properly staffed and should be welded with the other services. The health program should include services for staff members.

Some maternity homes do not have a hospital within their walls but arrange for obstetric service in community hospitals. If this service is given in the home, it should be given by a medical staff appointed annually by the board of directors on the basis of full knowledge of the staff's qualifications. The medical staff should be well organized and should meet regularly to review the medical care in the home.

(To be concluded in the October issue)

IN THE NEWS

White House Conference. The National Midcentury Committee for Children and Youth, a new committee whose job is to give national leadership in carrying out the objectives of the Midcentury White House Conference on Children and Youth, has been organized in accordance with the resolution on the follow-up program adopted in December 1950 by the 4,636 delegates to the conference.

Leonard W. Mayo, director of the Association for the Aid of Crippled Children, former president of the Child Welfare League of America, and chairman of the executive committee of the conference, has been elected chairman. Elma Phillipson, White House Conference consultant on participation of national organizations, has been appointed executive secretary.

Members of the new committee represent all parts of the country and many backgrounds of experience in work with children and young people. All serve as private citizens. Among the members are persons who were on the National Committee for the conference or on one of the three advisory councils—on State and local action, on participation of national organizations, and on youth participation.

The committee's relationships with Federal agencies will be maintained through five liaison representatives designated by the Interdepartmental Committee on Children and Youth to serve without vote. Those designated are: Katharine F. Lenroot, Children's Bureau, and Bess Goodykoontz, Office of Education, both of the Federal Security Agency; Henry L. Buckardt, Department of Defense; Mrs. Callie Mae Coons, Department of Agriculture; and Beatrice McConnell, Department of Labor.

In the 6 months following the conference, thousands of meetings were held to explore the implications of conference findings and to establish priorities for achieving conference goals; "Little White House Conferences" met in more than half the States; conference findings were studied by many national organizations; hundreds of articles appeared in popular magazines, professional journals, and newspapers. The Pledge to Children and other conference materials were widely reprinted throughout the country.

The National Midcentury Committee's program is designed to achieve the basic objective of the White House Conference—a fair chance for the healthy personality development of every child and young person. In line with this objective, it is recognized that citizens everywhere must continue to work toward strengthening and conserving family life amid the stresses of defense.

An important step that citizens can take in this direction is to join increasingly the planning, developing, and carrying out of programs for advancing the well-being of all the Nation's children and youth. State and local committees are a fruitful means of providing channels for increased citizen participation. Full cooperation of national organizations is essential. One of the committee's primary objectives will be to work toward ways of providing increasing opportunities for young people to participate in all appropriate aspects of community life.

The committee recognizes that, in accordance with the conference resolution on the follow-up program, "the chief operating groups upon which the responsibility for follow-up should fall will be existing organizations—National, State and local." To these the committee is offering the assistance of a small central staff to provide field service to State committees and national organizations and an information service on materials and media of mass communication.

National Commission dissolved. The National Commission on Children and Youth, appointed in 1946 by its chairman, Leonard W. Mayo, and the Chief of the Children's Bureau, Katharine F. Lenroot, has been dissolved as of July 9, 1951.

At its February 1949 meeting, the commission decided that the question of continuance of such a body should be considered in relation to the follow-up of the Midcentury White House Conference of Children and Youth, which met in December 1950.

This spring the commission's executive committee decided that with the organization of the National Midcentury Committee for Children and Youth to foster the follow-up program, the functions of the com-

mission would be in large measure performed by the new committee.

The National Commission on Children and Youth, since 1946, has given active leadership in planning programs for children and youth. Its reports, adopted at meetings in December 1946, January 1948, and February 1949, highlighted progress and pointed out areas in which further action was needed. Over 15,000 copies of its 1949 report, Moving Ahead for Children and Youth, were distributed. This report, which embodied the program of the commission, noted action needed in behalf of children and youth in fields such as adequate family income, good housing, health services and medical care, mental health and guidance services, educational opportunities, recreational services and facilities, educational and vocational guidance and placement services, social services, and legal protection for children and youth.

The National Commission in 1946 proposed the holding of a 1950 White House conference on children. It sponsored the March 1948 Conference on State Planning for Children and Youth that developed suggestions for State and local action in preparation for the conference. It participated with the Interdepartmental Committee on Children and Youth (Federal) in a Joint Interim Committee that advised on early preparatory activities. Several commission members were named as members of the National Committee for the Midcentury White House Conference on Children and Youth appointed by the President in August 1949, and others participated in the committees and advisory councils that worked with the National Committee. All members of the commission were invited to the conference; and many attended and took active part as speakers, leaders, and members of work groups.

The secretary of the commission submitted a final report on its action program, pointing out the many advances made between 1949 and 1951 on measures advocated by the commission.

The National Commission on Children and Youth succeeded the National Commission on Children in Wartime, appointed in 1944, which in turn had taken the place of the Children's Bureau Commission on Children in Wartime, appointed in 1942.

Included in the membership of each of these commissions were representatives of national organizations and professional associations and selected State and local leaders working in behalf of children and youth.

Day-care centers. For every child now in a day-care center, there is one or more on a waiting list, says the Child Welfare League of America. A sampling in eight cities, made by the League, discloses that applications for day-care services for children of mothers who are employed increased over a period of 5 months at rates ranging from 10 to 166 percent.

Dallas, Tex., reported an increase of 20 percent; Jacksonville, Fla., 25 percent; Fort Wayne, Ind., 30 percent; Minneapolis, Minn., 50 percent; St. Petersburg, Fla., 80 percent; Denver, Colo., 100 percent, and Lowell, Mass., 166 percent.

Atlanta, Ga., reported the smallest increase in these applications for day care (10 percent), though its center caring for Negro children reported an increase of 100 percent.

The League hopes its report will stimulate other cities to make studies of their own to find out how many children now need this type of care, and how many will be needing it in the immediate future.

Schooling for mentally handicapped. Implications for State and local school systems of the movement to establish day-school classes for severely mentally handicapped children were discussed at a conference held June 11–13, 1951, at Washington, under sponsorship of the Federal Security Agency's Office of Education. The conference was conducted by Arthur S. Hill, Chief of the Section on Exceptional Children and Youth, of the Office of Education.

Organizations represented included the National Association of State Directors of Special Education (representatives came from six States), the American Association on Mental Deficiency, the International Council for Exceptional Children, and the Federal Security Agency.

The discussions took into account the fact that legislation in a number of States, making such classes mandatory or permissive, has focused the thinking of educators and public welfare agencies upon a clearer identification of the problem of the need of mentally handicapped children for schooling; upon a formulation of objectives in establishing day-school services for such children; and upon consideration of what experiences would constitute an adequate program for children who are not adaptable to ordinary special-class programs.

It is expected that one outcome of the conference will be publication of a bulletin that will discuss these and other factors involved in providing for the needs of the more severely retarded who can be assisted through the establishment and maintenance of day-school services.

Age at marriage. More girls under 18 years of age are marrying now in the United States than were marrying at that age 10 years ago. Among boys of these ages the proportion hasn't changed.

Six out of every 100 girls from 14 to 17 years of age, a total of 249,000, were married; 15,000 more (0.3 percent) were already widowed or divorced in 1950. The figures for 1940 were 3.5 percent, or 168,484, married, and an additional 3,699 (0.1 percent) widowed or divorced.

Not as many boys as girls in this very young age group are marrying. In 1950, 11,000 boys from 14 to 17 years of age were married and in 1940, 15,249. In each of the 2 years these amounted to 0.3 percent of the boys in that age group.

From a BLS survey. Comparatively few social workers all over the country are devoting most of their time to services for children. In 1950 there were only 12,400 such workers in the United States in both private and public social agencies; 8,290 (two-thirds) were in State and local public agencies, operating in social-welfare agencies and institutions, in schools, and in courts. So reports the Bureau of Labor Statistics of the Department of Labor as a result of its study of salaries and working conditions in social work.

More than half of the workers, 6,643, were in public and private noninstitutional child-welfare programs, that is, programs that serve children chiefly in their own homes or in foster-family care. (The workers in this type of public program—the noninstitutional child-welfare workers—are, in general, the ones who carry out the child-welfare services for which the Children's Bureau grants funds to State public welfare departments.)

The graduate education of these workers and how much they were paid are also shown in the findings. Child-welfare workers in noninstitutional State and local agencies had had considerably more study in graduate schools of social work than had social-work employees primari-

ly responsible for public assistance, the report shows. Their graduate social-work schooling was also well above the educational accomplishment of the profession as a whole.

Forty-four percent of the workers in the public noninstitutional child-welfare programs had had a year or more of graduate social-work study, as compared with 27 percent for the social workers in all programs combined. But the workers in noninstitutional work in private agencies surpassed those in public agencies in professional education; that is, two out of three of the workers in private children's agencies had had at least a year of graduate study in social work.

The median annual salary for all persons in social-work positions was $2,960.

Median annual salaries for all case workers and group workers was $2,730.

For those in child-welfare programs, the median salaries were:

Noninstitutional child-welfare workers, $2,790; institutional child-welfare workers, $2,800; workers giving court service to children, $3,030; school social workers, $3,690.

The survey, in which the Bureau of Labor Statistics had the cooperation of the Federal Security Agency, the National Social Welfare Assembly, and the National Council on Social Work Education, reveals social work as a field of definitely low salaries.

Employment of students. More high-school boys and girls are taking on jobs outside school hours, according to a recent report of the Bureau of the Census, based on a sample survey made in October 1950. At the beginning of the school year 1950-51 an estimated 1.6 million boys and girls 14 through 17 years of age who were enrolled in school were also employed, or about 400,000 more than a year earlier. Nearly a quarter of all the boys and girls of these ages in the United States who were attending school were either employed or looking for jobs in October 1950; a year earlier the proportion was about one-fifth. Only at the height of World War II has this proportion been higher — approximately one-third in April 1944.

A considerable number of the student workers 14 through 17 years old—226,000 out of a total of 1,613,000, or 1 in 7—were employed 35 hours or more per week; and 693,000, or 3 in 7, worked from 15 to 35 hours a week.

In the present period of rising employment opportunity, these facts suggest that school and community planning and sometimes advances in State child-labor legislation are essential to insure that young students do not take on so heavy a burden of employment outside school hours that they risk both health and school progress.

This census report deals with the school attendance of all workers under 25 years of age and includes information not only on age and hours of employment, but also on sex, major occupation groups, and unemployment.

The report is titled: Current Population Reports: Labor Force, Series P-50. No.32. June 22, 1951.

Marriages and divorces. Marriages in the United States increased in 1950 for the first time since 1946, and divorces declined for the fourth consecutive year. These trends are shown by the preliminary figures of the National Office of Vital Statistics.

There were 1,669,934 marriages in the United States in 1950, an increase of 5.7 percent over the final figure for 1949 of 1,579,798 marriages. The marriage rate in 1950 was 11.0 (for every 1,000 of the population), and that for 1949 was 10.6.

The divorce total for 1950 was estimated at 385,000, compared with 397,000 in 1949, a decrease of 3.0 percent. The divorce rate for 1950 was 2.5 per 1,000 population; for 1949 it was 2.7 per 1,000.

UNICEF. Altogether 12 Latin American governments have contributed an approximate total of $1,650,000 to the United Nations International Children's Emergency Fund. They are Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, Guatemala, Haiti, Peru, Uruguay, and Venezuela.

A total of 18 Latin American countries and territories are now receiving UNICEF aid out of an overall allocation of $5,181,000 for the region. This international assistance is being used to help the countries to develop their own services for children and mothers; and in the conduct of large-scale campaigns against tuberculosis; diphtheria; whooping cough; malaria and other insect-borne diseases; and yaws and syphilis.

These countries and territories are: Bolivia, Brazil, British Honduras, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, and Uruguay.

United Defense Fund. Watch for the seal of this fund when national appeals for money are made to finance community services for the armed forces and for defense-congested localities.

Organized by Community Chests and Councils of America and the National Social Work Assembly, UFD will screen, budget, and unite appeals within the circle of federated financing in all parts of the country. Thus, the Fund is seeking its support in cities that have community chests and in New York City, in which a limited joint appeal is made. Nearly 85 percent of the people that support private health and social work through gifts live in these cities.

UDF has two units. United Service Organization (USO reactivated from World War II days) has the following member agencies to give services to the armed forces: YMCA; YWCA; Salvation Army; National Jewish Welfare Board; National Catholic Community Service; National Travelers Aid Association; American Social Hygiene Association; and Camp Shows. United Community Defense Services has the following member agencies to give services to communities congested by defense production; YWCA; National Organization for Public Health Nursing; National Recreation Association; National Urban League; Child Welfare League of America; National Catholic Community Service; National Federation of Settlements; National Travelers Aid Association; and the American Social Hygiene Association.

The major appeal will be for services to the armed forces.

For a social-work paper. An award of $500 will be made by a committee of the Alumni Association of the University of Pennsylvania School of Social Work for an original contribution in the field of social case work, or supervision, or social-work education. Deadline is December 31, 1951. For further information write to the Chairman of the Virginia P. Robinson Committee, Miss Mazie F. Rappaport, in care of Department of Public Welfare, 327 St. Paul Place, Baltimore 2, Md.

FOR YOUR BOOKSHELF

THE FIFTH INTERNATIONAL CONFERENCE OF SOCIAL WORK, PARIS, AUGUST 1950; preliminary notes. Published for the British National Committee by the National Council of Social Service, Inc. London, 1951. 49 pp. Copies can be had from the International Conference of Social Work, 22 West Gay Street, Columbus 15, Ohio, at $1; special price for members of the International Conference, 50 cents.

Important papers were presented at the Fifth International Conference of Social Work, and a valuable exchange of experience in the various fields of social work took place. The report of its deliberations, which will be issued later in 1951, will form the basis of further study and action in many parts of the world. In the meantime the "preliminary notes" published in this booklet will act as an introduction to the fuller report.

SOCIAL WORK YEAR BOOK 1951; a description of organized activities in social work and in related fields. Edited by Margaret B. Hodges. American Association of Social Workers, New York, 1951. 696 pp. $5.

Issued this year by the American Association of Social Workers instead of by its former publisher, the Russell Sage Foundation, the Social Work Year Book in 1951 maintains its high level of usefulness. We hear with deep regret that this is to be the final volume.

The eleventh issue of this biennial publication continues the original policy of presenting its subject matter so that it is a source of information to workers in other fields than social work. It is useful, for example, to social scientists, legislators, publicists, reference librarians, teachers, and boards of directors in many kinds of agencies, as well as to practitioners, administrators, and teachers of social work itself.

The Year Book does not confine itself to the field of social work. Because of the close relation existing between that field and several other fields, such as health, education, and religion, some discussion of subjects in these cooperating fields appear in the Year Book. The editors regard activities and agencies as "related" if their practitioners cooperate with social workers in serving the same group of clients, as does the public-health nurse, or if their problems and objectives touch closely those of social work, as does housing and city planning. Topical articles on these related services are treated in the same way as articles on the fields of social work.

As in previous issues, the subject matter is presented in two parts, the first consisting of 73 signed articles by authorities on the topics discussed and the second consisting of directories of agencies. The four new topical articles added this year are all of interest to workers in the children's field; Youthful offenders; Family life education; Social work and the national emergency; and Informal education.

Looking over the list of topical articles to see how services to children are treated, we see such titles as Adoption; Child welfare; Foster care for children; Homemaker service; Juvenile and domestic relations courts; Juvenile behavior problems; Maternal and child health; and School health services. Some of the articles that include discussion of their subject matter as it relates to children are on: The blind; The deaf and hard of hearing; The crippled; Labor standards; Public assistance (in its section on aid to dependent children); Public health; Public welfare; Recreation; Social case work; Social group work; and Social insurance. The article on Canadian social work includes a discussion of family allowances granted for children.

Hilary Campbell

YOU AND UNIONS. By Dale Yoder. Science Research Associates, 228 South Wabash Avenue, Chicago 4, Ill. 1951. 48 pp. Single copies 40 cents, 3 for $1. Quantity prices on request.

This little pamphlet, addressed to high-school students, contains a great deal of information on the labor movement. It gives a brief history of the labor movement in the United States and discusses union aims, collective bargaining methods, and union organization and government. Though directed to young people, it shows the relation of unions to all segments of the population. The pamphlet should stimulate teen-agers to learn more about labor unions.

Ione L. Clinton

CALENDAR

Aug. 27–31. National Council on Family Relations. Annual conference. Lake Geneva, Wis.

Aug. 31–Sept. 5. American Psychological Association. Fifty-ninth annual meeting. Chicago, Ill.

Sept. 3–7. Second International Poliomyelitis Conference. Copenhagen, Denmark.

Sept. 4–7. International Association of Governmental Labor Officials. Annual meeting. Seattle, Wash.

Sept. 5–7. American Sociological Society. Annual meeting. Chicago, Ill.

Sept. 6–11. National Conference of Catholic Charities. Annual meeting. Detroit, Mich.

Sept. 8–15. American Occupational Therapy Association. Thirty-fourth annual convention. New Castle, N. H.

Sept. 9–14. Fifth World Congress of the International Society for the Welfare of Cripples. Stockholm, Sweden.

Sept. 17–20. American Hospital Association. Fifty-third annual convention. St. Louis, Mo.

Sept. 30–Oct. 7—Christian Education Week. Twenty-first annual observance. Sponsored by the National Council of Churches of Christ, Division of Christian Education, 79 East Adams Street, Chicago 6, Ill.

REGIONAL CONFERENCES

American Public Welfare Association.

Sept. 6–8. Northeast States, Swampscott, Mass.

Sept. 20–22. West Coast States, Oakland, Calif.

Oct. 1 – 2. Southeast States, Nashville, Tenn.

Illustrations:

Cover and p. 10, Esther Bubley for Children's Bureau.

Pp. 3 and 4 Virginia State Department of Health.

P. 6, George Jones for Federal Security Agency.

P. 7, National Organization for Public Health Nursing.

THE CHILD

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AUGUST-SEPTEMBER 1951

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

A MESSAGE FOR "THE CHILD"

The Child is one of the most important means through which the Children's Bureau carries out its primary purpose of investigating and reporting on all matters pertaining to the welfare of children and child life. It began, in the first decade of the Bureau's history, as a mimeographed Weekly News Summary, prepared chiefly for the information of the Chief and members of the staff. In its present form it has reached a much larger audience. One of the most interesting tasks of my office has been the review of each number of *The Child* in manuscript form. In this review I have felt very close to the readers, the contributors, and the editor. Now as I leave my active connection with the Children's Bureau, I shall look to *The Child* to keep me closely in touch with the Bureau staff, and with the fellowship of people in our own and other countries who find a source of inspiration and inform tion.

As we look back over the ye since the Children's Bureau was cr ated we can see great accomplishments, but these gains have been accompanied by tremendous problems affecting all our people. Redoubled effort is necessary if the Bureau's final purpose, to help to assure for every child his fair chance in the world, is to be accomplished. May each number of *The Child* be a reminder to us all that the welfare of children is a test of our democracy, a test which must be met if our Nation, in cooperation with other free peoples, is to cherish and apply more fully the values inherent in personal freedom, civic responsibility, and spiritual growth.

Katharine F. Lenroot
Chief, Children's Bureau

U.S. GOVERNMENT PRINTING OFFICE 1951—952601

THE CHILD

OCTOBER
1951

UNITED NATIONS DAY, 1951

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the Charter of the United Nations, which came into operation on October 24, 1945, was designed as a firm foundation on which men of good will might build a world of peace and security; and

WHEREAS most of the members of the United Nations have cooperated faithfully in the effort to build such a world on the basis of the Charter; and

WHEREAS the United Nations has been engaged in the greatest effort ever made by an international organization to restore peace and security in an area of conflict; and

WHEREAS the General Assembly of the United Nations, by its resolution of October 31, 1947, declared that October 24 of each year, the anniversary of the coming into force of the Charter, should be dedicated to the dissemination of information concerning the aims and accomplishments of the United Nations, with a view to enlisting the interest and cooperation of all humanity:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby urge the citizens of this Nation to observe Wednesday, October 24, 1951, as United Nations Day, remembering that the anniversary commemorates a landmark in the history of the human race, and that its significance should be cherished in our hearts.

I also call upon the officials of the Federal, State, and local Governments, representatives of civic, educational, and religious organizations, and agencies of the press, radio, television, motion pictures, and other media of public information, to cooperate in arranging for ceremonies and programs on United Nations Day, designed to acquaint our citizens with the activities of the United Nations, to the end that we may forward the work of this great international partnership.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the city of Washington this twelfth day of September in the year of our Lord nineteen hundred and fifty-one, and of the Independence of the United States of America the one hundred and seventy-sixth.

Harry Truman

By the President:

Dean Acheson

Secretary of State.

NEW CHIEF TAKES OFFICE

Martha M. Eliot, M.D., the new Chief of the Children's Bureau, is well known to all who work with or for children. For the past 2 years she has been an Assistant Director-General of the World Health Organization. Before that Dr. Eliot was for 25 years on the staff of the Children's Bureau, 15 of those years as Assistant or Associate Chief.

After joining the staff of the Children's Bureau, Dr. Eliot for 10 years directed Bureau studies of the growth and development of children. During this period she wrote one of the early revisions of Infant Care. She became Assistant Chief of the Bureau in 1934, and Associate Chief in 1941. In these capacities she headed the health and medical services of the Bureau, which include the maternal and child health and crippled children's programs under the Social Security Act.

In 1949 Dr. Eliot became an Assistant Director-General of WHO. There she gave new impetus to development of public-health services in countries asking for help from WHO. She gave special attention to the cooperative relationships of WHO with the United Nations International Children's Emergency Fund.

THE PRESIDENT has done me great honor in appointing me as Chief of the Children's Bureau. It is with satisfaction and pleasure that I return to work with so many old friends, but it is also with a sense of great responsibility. To follow in the footsteps of such great leaders as Julia Lathrop, Grace Abbott, and Katharine Lenroot is no easy task.

Each of these leaders has been a vigorous champion in the cause of a better life for children. I have had the extraordinary advantage of having worked closely with two of them—Grace Abbott and Katharine Lenroot. I have seen them in action and have learned much from them. I want to pay tribute now to the skill, the imagination, the wisdom, and above all the unfailing integrity that they showed in developing the work of the Bureau. Each of them encountered many difficulties and barriers to progress. Certain limitations to the scope of the Bureau's work had to be accepted; but there was no limit to their vision of what could be accomplished for children, and there was no limit to their courage in pressing for action. The result has been tremendous progress in child health and child welfare.

But, as we all know, the job is far from being finished. The situation created by current international tensions, by the demands of the national defense program, may make progress today more difficult. With ingenuity, however, and foresight in planning, I believe much can be done. I know that the Bureau can count upon the cooperation of the many public and voluntary agencies and organizations—National, State, and local—which also have facilities and opportunities for work in behalf of children.

As I return to the United States from my work with the World Health Organization, I am impressed with the great advances that have been made here in applying the newer knowledge of child care, but I am aware also of the need for further research and investigation to establish new facts, to learn new methods for improving the conditions surrounding the lives of children. I see, too, the present gaps in our action program.

Fortunately, as we enter the second half of the twentieth century we have new guide lines for action, laid down by that great group of citizens that came together under the sponsorship of the President for the Midcentury White House Conference on Children and Youth.

That conference did a magnificent job in mobilizing citizen concern for children. And we must continue to work through the close tie-ups that it encouraged between citizens as a whole and workers in public and private agencies for children. For it is through such tie-ups in the local communities where the homes and families are that the job must be done for and with children.

As we strive together to do that job, we must uphold the principle that the child's health and his social welfare are inseparable. This is the principle on which the Children's Bureau was founded — that every aspect of child life is bound up with every other aspect, and that the Bureau should be a focal point, where all matters related to the well-being of children would have the undivided attention of a staff devoted to the interests of children. My acceptance of appointment as Chief of the Children's Bureau carries with it my acceptance of that principle.

Martha M. Eliot

MARTHA M. ELIOT, M. D.
Chief, Children's Bureau

FOR THE WELL-BEING OF CHILDREN IN CITY DAY CAMPS

DURING THE PAST summer, while many of New York's children went camping in the mountains or in some other place away from home, large numbers did their "camping" near enough to their homes to return there at night.

Since the children go home every evening after the 6 to 8 day camp hours are over, they of course miss some of the experiences in independence that go with 24-hour camping. But some children are not yet psychologically ready for the full camping experience; and others cannot go to residential camps for other reasons. A good day camp enables a child to be close to his parents during the summer and helps him to occupy the greater part of his active day safely, constructively, and happily.

This brings up the question, what is a good day camp? And since day camps, which began to expand during World War II, now care for nearly 100,000 children each summer in New York City, this question has become a serious one. Most of the camps are operated by nonprofit organizations; some by private owners. No official agency supervises or regulates them, for existing health-department regulations cover only children under 6, and many of the day camps take children up to the age of 16.

Since day camps began to expand rapidly, private citizens and representatives of health and welfare agencies have become concerned about the conditions under which the children were cared for. Complaints kept reaching the city department of health that many of the camps were unsafe, unsanitary, or otherwise undesirable.

Last year a survey of the day camps was made by a staff of physicians, teachers, nurses, social workers, and sanitary engineers, under the direction of the department of health, and they found that many of the complaints were justified.

Children can tell if the day-camp counselor really likes children and enjoys being with them.

This year a grant of $30,000 was made to the department by the New York Fund for Children to be used over a 2-year period to survey conditions in the camps and to find out what improvements are needed to safeguard the total health of the children attending them. As of July 1, 1951, a Day Camp Unit was organized in the Division of Day Care and Foster Homes of the New York City Department of Health, with a staff consisting of three full-time camp consultants, supplemented during the summer by a number of public-health physicians.

During July and August — the period when most camps are open— the staff members of the Day Camp Unit visited a large number of camps, and their observations confirmed those made in the 1950 survey. Though some of the camp programs were meeting good standards, many were unsatisfactory; some were even hazardous for the children.

Too often the camps did not have suitable premises as a "home base." The home base is where the children gather each day, and from which they start on their trips, picnics, and hikes. An adequate home base is a requisite of a good day camp program; it gives a child the stabilizing

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This material was developed by the staff of the new Day Camp Unit of the Division of Day Care and Foster Homes of the New York City Department of Health. These staff members are: Cornelia Goldsmith, Chief, Division of Day Care and Foster Homes; Minerva Golden, Head, Day Camp Unit; Lillian Margolin, Consultant, Day Camp Unit; Laurence Farmer, M.D., Part-time consultant, Day Camp Unit; and Joseph Kadish, Consultant, Day Camp Unit.

influence of a familiar place, where he regularly "hangs his hat" during the camp season.

Most good camps were found to have outdoor space next to their indoor premises. Some kept the children at public parks, playgrounds, or beaches most of the day, with little or no protection from sun and rain. Some camps had indoor space to use in bad weather only, but the space was too small, and on the days when the children needed to stay indoors the overcrowding produced bedlam.

As for sanitary facilities, in only about half the camps were toilet facilities adequate when the children were indoors. Some provided only one toilet for 30 to 70 children. In many camps the outdoor play space was too far from the indoor premises, where the toilets were. Often drinking and washing facilities were totally inadequate.

The opportunity to contribute to the health of children has not been fully recognized in many of the camps. More than 75 percent of the camps had arranged to have the children examined by physicians before the camp opened; but only 60 percent had arranged for such examinations of their staff members. In some, examinations were cursory; if health records were kept, they were incomplete or inaccessible.

In many camps the lunch was badly planned and nutritionally inadequate. Usually it was too high in carbohydrate foods, such as rice, macaroni, and spaghetti, and it lacked protein foods and green and raw vegetables. Mayonnaise, jam, or jelly were used as a spread for bread instead of butter or margarine.

Much depends on human relations

Any summer play program must be evaluated by the benefits that children gain in physical health and social and mental well-being. Fundamental to the development of good mental health are satisfying and challenging activities and good human relationships among the children, among the adults, and between the children and the adults. In a group program this requires guidance by warm, friendly, mature directors and counselors—people who know and understand the growth and behavior patterns of normal children. The training of these workers should include previous experience with children, under competent supervision, and some experience with the age group currently assigned to them.

As for the formal training of the camp directors, the survey revealed that the majority were college graduates in some area of education, recreation, or social work with special training in group work. Four of them however, were not even high-school graduates. Many had no training or experience related to the ages of their campers.

The ages of the counselors ranged from 12 to 57 years; about half were between 16 and 20.

The survey revealed that about one-fourth of the camps employed counselors who were under 16 years of age. In fact, of the counselors who had sole responsibility for a group of children, 12 were 15 years old, 4 were 14, 1 was 13, and 3 counselors were only 12 years old!

A concerted effort is needed to improve the quality of the counseling in the camps; a step toward this would be to increase the number and improve the quality of counselor-training courses under professional auspices.

The need for better conditions has long been known to persons who have worked among children in summer day camps during the past several years. Interest in developing higher standards of service to these children has become the concern of many individuals and groups. A committee composed of representatives of child-welfare agencies was formed last year under the direction of two New York voluntary groups, the Welfare Council and the Children's Welfare Federation, to develop such standards.

The standards established by this committee as a guide for day camp programs emphasize health services, physical facilities, sanitation, food organization, program, registration, transportation, insurance, records,

Quiet occupations like making puppets offer variety in the active programs of day camps.

and staff. Some of these standards are briefed here.

A good health program, the standards suggest, should strive to maintain a balance between appropriate physical activity and rest, and should pay special attention to nutrition.

Pre-entrance medical examinations of the children and of the entire personnel of the camp should be obligatory, so as to assure that only healthy persons—children or adults—are admitted to the camp or allowed to participate in its activities. The information obtained from the physical examinations would also help make it possible to individualize the camp health program. Some children with physical handicaps can safely and profitably go to camp, but it is important to know what limitations the handicap puts on their activity.

Also, a good health program should include daily inspections to detect signs of illness; rest periods, which are an important part of the camping day; and nutritious meals and snacks. The camp should be ready to deal with emergencies—accidents or sudden illnesses.

The standards urge that the camp should arrange in advance for the services of a physician, preferably a pediatrician, who will be responsible for planning the health program. He should have access to all health records of children and staff, so as to make necessary medical recommendations. He should discuss problems with the staff. He also is responsible for carrying out department of health regulations concerning communicable diseases.

To carry out these duties, it is not always necessary for the physician to give full time. He must, however, visit the camp and be completely familiar with the physical set-up and the daily program of activities. He should be consulted whenever the need arises.

In addition to meeting city regulations concerning housing and fire prevention, the indoor premises should provide adequate space for children's play. This space should be free of hazards, and be well-lighted, well-ventilated, and clean, with an ample number of toilets, wash basins, showers, and drinking fountains.

A safe and sanitary outdoor play space should be provided, with a minimum allowance of 50 to 75 square feet for each child.

Outdoor locations that are used on a continuing basis for summer group programs for children should be provided with suitable shelter to protect the children from inclement weather or from the hot summer sun; or else immediate means of transportation to such shelter should always be available. Outdoor locations should have adequate and accessible drinking water and toilet facilities.

Standards put safety first

Swimming, of course, is one of the most popular and enjoyable activities of all summer groups, and the standards urge that, when using swimming facilities, public or private, day camps live up to the requirements of local sanitary codes and of accepted safety regulations.

The children should be divided into small units, the standards say. The size of the groups will depend upon the age, sex, and interests of the children and on the camp's facilities, staff, and budget. Experience shows that for children 6 to 8 years old the best number in a unit is 10. For children 9 to 12 years or over a unit should include no more than 12 or 13 campers. When it is difficult to have small group units with one counselor each, it may be necessary to assign two counselors to a larger group—not more than 25 children.

The small group unit generally stays together for most of the camp day. The limited size of the unit permits each camper to take an active part in every activity, to have a sense of belonging, to use his initiative and develop judgment, and to have a closer relation with the counselor.

Since a unit of 10 to 12 children requires a high degree of conformity to group decisions, which may tend to prevent the individual from developing or exploring some of his own personal interests, it is especially necessary to consider this limitation and provide for individual interests and skills. For children from 9 to 12 years, individual differences in interests, tastes, and skills manifest themselves sharply. The well-planned camp provides special-interest activities particularly for children over 9, such as hobby groups made up of members of various unit groups.

The small groups may then join from time to time to form divisional units, each under the direction of a division head. Experience suggests the following divisions: children 6 to 8 years of age: 9 to 10 years; 11 to 13 years; and those over 13. Such organization permits the camper in the small unit to feel himself part of a larger group. It encourages intergroup activity and brings boys and girls together. Also, some worth while games and other activities require a large number of children. The large groups may take part together in trips, team games, festivals, ceremonies, and similar programs. The best size of divisional groupings is not more than 50 to 60 youngsters, according to the standards.

To permit campers to acquire new experiences in crafts, woodwork, dramatics, music, newspaper work, and other activities, special-interest groups may be scheduled several times a week. In some day camps the small group unit, as a whole, travels from activity to activity. In other camps each child chooses his own activity during hobby time and at the end of the period returns to his group.

Most campers will have had previous experience with other children of their own age at school. Day camping should be an experience in which the child finds companionship, a feeling of belonging, interesting things to do, and new fields to conquer. Staff and parents should exert every effort to achieve this.

The vehicle through which these objectives can be achieved is the program itself. Basically, "program" includes the entire range of

What can it be? A frog or a toad? City children here can learn about nature at first hand.

activities, relationships, interactions and experiences, both individual and group, which are carefully planned and carried out with the help of the counselor to meet the needs of the individuals and the group. It is a process, not a system of scheduling activities.

A well-rounded day camp program includes a variety of experiences, such as swimming, group games, arts and crafts, hikes, picnics, outdoor cooking, nature lore, music, dramatics, trips, and so forth. Very often many of these activities are centered around a theme of special interest to all the children in a camp.

Specific objectives for both individual and group growth must be clearly determined by the leader. These objectives must be in harmony with the wishes of the group and the capacities of the individual. Also, the objectives must be in keeping with the stated philosophy of the camp.

The family's introduction to the day camp takes place at the first interview. Here a camp worker may set the tone for the feeling of the parent and the child about the day camp and its program. The worker may also observe the behavior and general attitude of the child and the relations between the child and the parent. He may learn what the child and his parent expect from the program, and may consider whether the child can benefit from attending the day camp.

Both the parent and the child should be given an initial description of the day-camp program. Fees and other expenses should be clearly explained to the parent; and information should be given about such things as bus service, clothing needed, medical requirements, and services offered by the day camp.

Parents and day camp worker confer

The worker should talk over with the parent the reasons for sending the child to the camp. The parent should be given a chance to discuss freely the child's problems and needs and should be helped to determine whether the service being offered is appropriate for the child. The worker must be able to explain the organization and program of the day camp in such a way that the parent can make a wise decision about enrolling the child.

When it is decided that the child is to be enrolled he should be given a general idea of the activities and of the group he is to join. The parent should be helped to appreciate the importance of his cooperation during the adjustment period and the fact that the parents and the worker must join to help make the experience in the day camp a good one for the child.

The success of the program depends largely on the quality of staff. The program director and all who supervise the day-by-day activities should have at least a college degree or the equivalent, in education, or recreation, or social group work, and should have had substantial and recent experience with children of comparable age in a camp or similar group, under professional supervision. They should also have a knowledge of community resources and how to use them.

Workers directly in charge of a group of children should also have had training for work with children of the age included in their group. They should have had at least 2 years of college or the equivalent, in education, recreation, or social group work and preferably should be at least 20 years of age. Because of the seasonal nature of day camps exceptions may be made when an applicant without the desired training has outstanding personality qualifications and special abilities.

The counselors in day camps live in close daily contact with children and have a significant and often long-lasting influence on them. Under skilled and mature supervision, a person of 17 or 18, who really likes children and who has had training in counseling, can be a good assistant counselor. But if the counselor is to be in charge of a group, he should be at least 20 or 21 and should have had training and experience in working with children. Young and immature high-school students and others with no real understanding of their responsibilities or of the behavior and growth and development of children can do great harm.

If the sponsors of a day camp wish to engage young junior counselors they should be at least 16 years of age, and the director must appreciate the additional responsibilities inherent in employing these young people. Junior counselors should not be employed unless the camp can provide the supervision

necessary, as well as the necessary pre-camp instruction. At no time should a junior counselor act as an independent group leader.

All counselors should have genuine liking for children, respect for their individual differences, and understanding of their needs; emotional stability, stemming from inner personal security; initiative and creativity in developing a program; ability to lead and to make imaginative use of resources; ability to understand fully and support the policy and program of the organization; and the ability to handle the administrative part of the job well.

Children at different age levels need different types of counselors, the standards point out.

Campers from 6 to 8 years of age are not physically or emotionally ready to engage in highly organized group activity; the counselor must be able to provide constructive opportunities and appropriate materials for individual and small-group play. This age group requires a schedule and a program that allows for large-muscle activity and yet minimizes fatigue. Experience shows that counselors with successful experience in teaching groups of young children usually are the most desirable leaders.

At 9 or 10 years of age, children are ready for a more integrated group experience. Rivalry for leadership, aggressive behavior, and competition are part of their adjustment to group living.

The counselor for these children should understand the problems they have in learning to adjust to a group. A counselor in this age division needs to know appropriate games, simple crafts, nature lore, plays, songs, simple dances, and discussion techniques.

In the age group 10 to 11 years, children need to feel increasingly sure of their status. They often refuse to associate with younger children and may even resent their presence, but they themselves are generally not accepted by teenagers. If there are only a few children of this age, and they have to play with younger children, they may lose interest. However, if the staff can provide adventuresome activities for them, they can get satisfaction out of day camping.

Counselors of teen-age groups must understand that adolescents still need support and control, but at the same time wish to be treated as grown-ups. Here the counselor again must be a real leader. He must himself be skilled in athletics and other activities. He also needs to be sensitive to the attitude of the group toward other youngsters of their own sex and of the opposite sex, and toward older people, and sometimes to a new self-consciousness in relations with persons of racial or cultural backgrounds different from their own.

A day camp staff needs skill in encouraging satisfying relationships between boys and girls, proficiency in sports, skill in using new forms in dramatics for social development, and ability in developing relationships between individuals and groups. Thus they need to be able to adjust themselves to differences of sex, age, and cultural background.

Camp philosophy and program are described to every staff applicant during the hiring interview. This sets the tone for the counselor's subsequent contacts with the director and for his attitude toward the job. Camp administrators should consider writing a statement of camp objectives and of personal practices for the information of the staff. When the program does not follow the usual pattern it is doubly important to clarify its aims.

A good training program for day-camp workers should include: History of the development of resident camping and day camping; benefits of day camping to the individual and to his family; how to develop small groups and why; content and value of intergroup activity; camp government and discipline; normal growth and development of children; behavior of individuals and how to develop initiative and judgment; program activities for large and small groups and for the camp as a whole; health and safety factors; sources of program material; staff ethics; parent-staff relations; records and reports.

As a part of training, a pre-camp staff training period of 1 or 2 weeks is necessary, according to the standards. Weekly or fortnightly supervisory conferences are desirable.

Planning to give summer recreation to the children in our large cities is an urgent need. Day camping has much to offer, but the service must be good. Exposing children to poor conditions must be prevented. Through surveys such as the one in New York City, through the radio and the press, and through the education of parents and professional workers, it is hoped that wholesome programs for all children will be attained.

Without staying away from home, these children have a chance to be close to the soil.

Reprints in about 6 weeks

A youngster's first job is likely to be just a routine one, and any satisfactions found must come from the new environment, the new personal relations, the new income and status.

FROM SCHOOL TO WORK

Boys and girls need preparation before taking jobs

R. MAURICE MOSS

AFTER a child grows up, probably half his waking hours will be spent on the job. And if he is to have a healthy personality, his job ought to be a source of certain satisfactions. It represents a release from the dependency he has felt toward his parents. It is the beginning of something to which he has looked forward as a cherished mark of adulthood.

As Gertrude Folks Zimand, Executive Secretary of the National Child Labor Committee, has said, "Work is not merely an economic necessity; it is part and parcel of the fabric of living. A person's adjustment to, and satisfaction in, his occupational activities, whether in industry, a profession, or the home, is an important factor in his general effectiveness as a person. A child-labor and youth-employment program, therefore, must be concerned with all the implications of 'work' in relation to the growth and development of young people."

Wrong job can injure personality

But if the job is beyond the child's ability, or his preparation; or, on the other hand, if it does not challenge his capacities—does not offer the hope of development and growth — such a job can serve to intensify his feelings of insecurity. This can affect his work relations and his general attitudes and outlook. Under such conditions it is difficult for the boy or girl to develop a healthy personality.

Employment of children and youth when they are too young to leave school or are not in physical condition to do the work, or when the job is too hazardous for a young worker, physically or morally, has been battled successfully over the past century. Witness the legislation now in force on compulsory school attendance, hazardous occupations, minimum age for employment, maximum hours for workers of certain ages, and so forth. Even though certain sore spots still remain, such as the work of children in street trades or as agricultural laborers, and especially of children in migratory families, on the whole employed children and young people are well protected from the main evils of child labor. And in 1950 employment of children under 16 during school hours was probably at its lowest point in history.

In spite of everything that has been done to keep children in school at least till they are 16 years of age, a considerable number of boys and girls between the ages of 14 and 18—and for that matter, of children even younger — leave school every year to take jobs. Then some leave school as soon as the law allows, because they have no interest in formal schooling, or capacity to benefit by it. Large numbers leave because the need for supplementing the family income is compelling. Each year approximately a million and a half persons seek their first jobs.

And, though much has been done to protect these boys and girls from industrial accidents and health and

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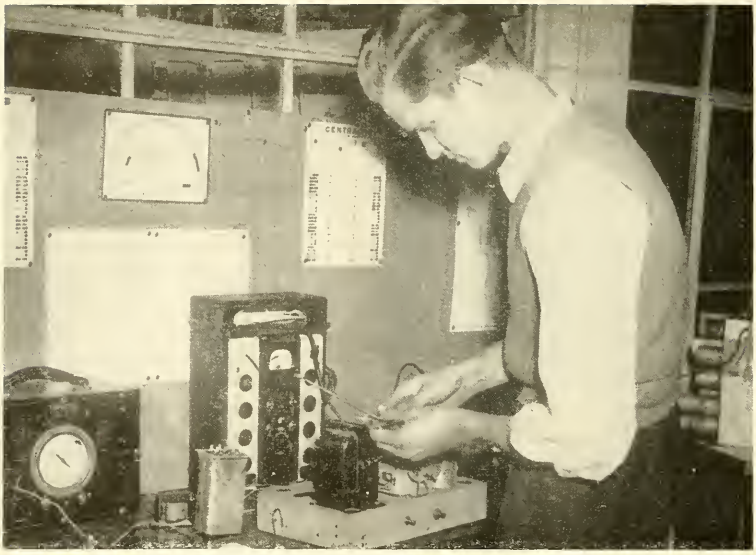
R. Maurice Moss is Associate Executive Director of the National Urban League. A graduate of Columbia University and of the New York School of Social Work, Mr. Moss has served the League in Toledo, Ohio; Baltimore, Md., and Pittsburgh, Pa. While in Pennsylvania he was on the Governor's Commission on the Urban Negro Population, the Allegheny County Board of Public Assistance, and the Interracial Advisory Committee of the State Department of Welfare.

This article is based by Mr. Moss on a paper that he prepared for the Midcentury White House Conference on Children and Youth. The paper is one of a number that served as resource material for the Fact Finding Report of the Midcentury White House Conference on Children and Youth, which is to be published in the fall of 1951. The procedures of the conference did not provide for official approval of these papers. Address inquiries to National Midcentury Committee for Children and Youth, FSA Building North, Fourth and Independence Avenue, S. W., Washington 25, D. C.



If a young person's working life is to contribute to the development of a healthy personality in the worker, the job itself should be a source of psychological satisfactions to him.

moral hazards, far too little attention has been paid to the educational and psychological factors in the employment of these children, who today are pupils and tomorrow employees.

It seems to me that further steps should be taken by public and private agencies — industry, schools, and employment services — acting together, to improve and increase the services they are rendering to boys and girls at the point where these young people actively seek employment. These three groups should set up more machinery for referring young people to job opportunities in accordance with their aptitudes, their limited skills, and their continuing educational interests. This may mean after-school work, or part-time work with educational value that gears into ongoing school programs. Or it may mean a full-time job that is psychologically satisfying to the young person because it takes account of his individuality and therefore builds toward permanent work interests and habits.

I have linked the efforts of public and private agencies because even the best laws, plus appropriate administrative procedures for implementing these laws, cannot alone meet the multiplicity of problems inherent in youth employment. Interpreting the problems to the community, furnishing guidance, and doing a large share of the thinking and planning toward solving these problems must be the responsibility of nongovernmental agencies. A comprehensive program can be developed — a program designed to serve equally well the interests of the individual child and those of his prospective employer.

Family, school, and industry

Such a program should meet three needs: (a) the need for development of sound measures that will increase family income; (b) the need for closer gearing in of education and employment while the child is still in school; and (c) the need for stressing the role of industry itself in this program.

The child starts as a member of a family group, and that group's economic stability will materially affect the child's own life as a worker. An adequate family income will provide satisfaction for his material wants, will remove fears and insecurity, and will assure the opportunity for adequate schooling. The findings of the Midcentury Conference with regard to family income, and the results of other investigations — I have in mind particularly the study of low-income families made in 1949 by a Congressional committee — should be coordinated and correlated. Whatever strengthens the family's economic position will affect child life favorably.

For an easier transition

When a child first enters employment he encounters as a rule too sharp a break between school and his first job. Usually this is a routine job, and his satisfactions in it must come from the excitement of a new environment, new personal relations, a new income and status. The more gradual the transition between school and job can be made, the better for our future workers. In many school systems this is being done through a well-supervised work-school program, under which boys and girls of legal working age are employed part time and go to school part time, through cooperation between employers and the local board of education. We need more of these bridges between the classroom and the workshop.

In this connection we must note the vast importance of proper facilities for vocational guidance as one of the major ways of easing the child's transition from pupil into worker.

The school has as its focus the development of the individual. But the young worker finds that industry is geared differently; the individual is only an incidental interest. Yet we must not forget, nor must we let industry forget, that a large part of the individual's life will be spent at work, and that industry itself has a contribution to make toward the young worker's healthy personality development.

I believe that industry can be interested in assuming its share of responsibility; that, in fact, it already has such an interest, and we need only seek, and help to develop it. Let me cite an example of how industry provided emergency funds to keep in operation a community

agency for young workers, which had been originally established with public funds.

This agency, called a trainee acceptance center, has been carried on since 1944 in Pittsburgh, Pa. It is one of two such centers established in Pennsylvania on an experimental basis with State and Federal funds, under the sponsorship of the State department of public assistance, which has an interest in putting people in a position to help themselves. The center tests individuals to determine what type of training they can best profit by, what types of work they can do most successfully, and what levels they are likely to be able to attain.

In this testing the techniques of clinical psychology are applied to occupational guidance. The center tries to evaluate the individual's level of ability, some of his specific aptitudes, his pattern of interests, his personality adjustment, and his physical condition, all in a day's testing.

To help both employer and worker

The philosophy of the center is that the type of work that is most suitable and satisfying for the individual is also the type of work by which he can make his best contribution to society. The center firmly believes that, in the long run, satisfactory vocational adjustment serves equally well the interests of the individual and those of the employer.

In wartime, this point of view aided industry and business in making the most economic use of manpower. In the first year and a half there were over 2,000 people tested at the center. It had referrals from schools, industry, government agencies, and social agencies; and many people came in on their own.

By the time the war ended, the Federal and State funds were no longer available. But the center had proved so worth while that industrial concerns joined in furnishing financial support until a substantial grant from a private foundation (the Buhl Foundation) placed the work on a permanent basis. The staff now numbers 14, and the persons tested amount to about 2,200 a year, one-fourth of whom are referred by schools. By arrangement with the city board of education the center has moved into larger office space in the Schenley High School, and about 500 students of that school are tested and counseled each year. Under a 3-year grant from the Buhl Foundation a program of research in vocational psychology is being carried on, aimed especially at improvement of techniques in vocational guidance of high-school students.

This is but one sample of the kind of community action that I have in mind. It is a significant example because it involves the cooperation of the educational forces, of the public-assistance officials, of a private foundation, and of industry, in a program to assist the prospective worker.

A young person who has had vocational guidance can more easily make the transition from school to employment. And the more gradual the transition, the better for the future worker.

Toward suitable employment of youth

Fuller collaboration on a formal basis, of the kind I have described, is needed between government, school authorities, industry, and various public and private agencies. If this can be done at the planning and policy levels I am confident that the administrative machinery can be set up and jointly financed. This kind of effort would go a long way toward assuring suitable employment opportunities and good working conditions as factors in the development of our youth.

As a member of the Midcentury Conference phrased it:

"The richest resources of our land are the children who inhabit it. Shall we protect, conserve, and develop these resources? Or shall we permit their dissipation?

"The answers appear evident from the questions; yet many of these resources are being wasted or misused. They are wasted when boys and girls who can learn and who want to learn are compelled to cut short their schooling because of economic need. They are misused when students are forced to choose between leaving school and accepting a school experience that does not meet their needs. They are dissipated when young people engage in a lifetime of work yielding little satisfaction.

"Children grow in a world fashioned for them by adults. We have an obligation to create for them the most favorable conditions for their most constructive growth."

Reprints in about 6 weeks

TO STRENGTHEN MATERNITY-HOME SERVICE FOR UNMARRIED MOTHERS

(part 2)

EDITOR'S NOTE: This is the second part of an article that began in our August-September issue. (We shall be glad to send a copy of that issue to any reader who missed part 1.)

In part 1 of the article, Major Wrieden discussed the foundations of a good program for maternity homes for unmarried mothers. She believes that the complexity of the difficulties these mothers face calls for the services of qualified specialists. The services of a social case worker, social group worker, psychiatrist, and psychologist should be available, as well as the services of an obstetrician, pediatrician, and nurse.

JANE E. WRIEDEN

HOW TO provide adequate nursing supervision and care for mothers and babies in maternity homes is a question that needs careful study. As I have said, some of the homes provide delivery service within their own walls and others send their patients to community hospitals for delivery. It goes without saying that whichever plan a home follows it should give the mothers and babies the highest quality of nursing care that they would get anywhere.

Although some of the homes do not provide delivery service, all of them provide the advisory health supervision that nurses give to mothers before and after delivery for themselves and for their babies. Is it essential for a small home to have on its own staff three registered nurses for round-the-clock coverage with at least one registered nurse for relief, as some homes do? At times this may be a high proportion of nurses for the number of patients needing their supervision or care. If funds are used in this way, the home may not have enough money for other necessary parts of a maternity-home program.

Perhaps the answer to the question is that some of the nursing supervision and care should be provided otherwise than by nurses on the staff of the home. For example, could public-health-nursing agencies that give maternal and infant care to mothers and babies in their own homes give it also to mothers and babies in maternity homes for unmarried mothers? Incidentally, if that plan of cooperation could be worked out, it would emphasize the fact that these homes are a vital part of community services.

State departments of health could help in finding answers to this question, because of their concern with the quality of all maternal and infant care, and State departments of welfare could also make valuable contributions. Directors of maternity homes and representatives of public and private health and welfare agencies could to advantage plan a series of conferences for considering this question.

Do we know enough, as the result of sound research, about the proper ratio in a maternity home of staff members to residents? One State, for example, requires for licensing at least one staff member on duty for each ten adults, one nursing staff member for each six babies, with no fewer than two staff members on duty at all times and with a registered nurse responsible for care at all times. The size of the staff should depend on the percentage of occupancy rather than on the home's capacity but, regardless of capacity or occupancy, certain activities are essential, such as administration, case work, nursing, housekeeping, laundering, serving meals.

One person sometimes carries the work of more than one of these activities. I question whether an administrator can successfully direct the home and also carry the duties of a specialty, such as nursing or case work. The important point is to have a sufficient number of staff members qualified in their field so that each part of the work can be well done and the home is not dependent on the residents for work that should be done by full-time or part-time employees.

A maternity home, like any social agency, is only as good as the workers on its staff. It should use good personnel practices in order to get and keep good workers. A regular staff is strengthened by the use of volunteers — both men and women — carefully selected, instructed, and supervised, and given a chance to do well-planned, worthwhile tasks.

Of course a maternity home needs a good building, well equipped, well furnished, and also located in a desirable neighborhood. Fire and accident hazards must be eliminated. I suggest another need for study — what constitutes realistic standards for a safe and adequate building for a maternity home in the light of this particular service and the limitation of funds many of us face? Some of us have to work in old buildings—of both institutional and residence type—unsuitable for this purpose.

In the maternity home where I work, we are having a grand time fixing up a very old, drab, meagerly equipped former family residence, through the teamwork of staff, board, residents, and volunteers. From this experience I suggest that others who are struggling with run-down houses try not only to make them safe and convenient, but to recapture the charm and atmosphere that these residences once had, and so make them a suitable background for our particular form of group living.

How much money is needed?

It takes money to develop a good maternity home. We should learn just how much it takes; we can learn this only through reliable studies. We should give the financial facts we learn to our contributors and potential contributors. We must help community chests to understand the nature and quality of our programs, how much they cost, and why. We can do this best through analyses made by accountants qualified to work out the cost of units of service.

The home in which I work has a

capacity of 26 adults and 15 babies, with an average adult occupancy rate last year of 83.5 percent, and with nearly 13,000 obstetric and pediatric days' care for the fiscal year ended September 30, 1950. Our unit costs per day during the period were as follows:

Maternity-home care for adults	$2.69
Nursery care for infants	4.13
Hospital care for adults	9.90
Care of newborn infants	4.93

The average cost of a delivery was $26.00. The cost per meal of the raw food was just under 29 cents, and the cost of serving it was just under 12 cents. In determining the cost of providing services we include in addition to regular salaries and wages the value of the services contributed by the few staff members who do not receive salaries comparable to the rate of pay for similar positions in the community at large. In accountancy these contributions are usually called "donated services." They are considered in the cost analysis of other types of health and social agencies besides ours.

Do we in this field need some careful studies of maternity-home costs? My agency believes that we do and is now working on some comparative studies of our various homes in the eastern States.

Sound financing requires a carefully thought-out budget, in the preparation of which all members of the staff and board take part. Budgets should be realistic and elastic and should be reviewed frequently in the light of actual costs.

Related to the cost is the average occupancy rate. Hospitals consider an occupancy of from 80 to 85 percent satisfactory. Can this figure be applied to a maternity home for unmarried mothers? The occupancy rate depends on the programs, policies, and practices, because unless we are offering what unmarried mothers need, the homes are only partly used.

The fee charged for care is another point of issue for those who give maternity-home service and for those who use it. Are some clients by-passing maternity homes because of the fee? Are some agencies reluctant to refer a client to a home because the cost seems prohibitive? A clear-cut administrative policy and the skill of the case worker is greatly needed here to determine when to waive or to reduce the home's fee for a particular applicant, keeping in mind always both the ability of the girl or her family to pay it, and the actual cost of the service. Being successful in explaining to the board of directors, to the community chest, to other agencies, and to the public how much good maternity-home care costs, and why, tests the skill of the home's director. Out of this relation of cost to a young woman's need for the service, even though she is unable to pay for it, may come new practices. More careful selection of applicants and greater use of other services, such as family foster care for unmarried mothers, may result.

Maternity home needs community's interest

How many administrative problems are related to the closeness of the home's contact with the public, or its lack of contact! To insure good services for unmarried mothers, a home must have good community relations. We must tell our story in a simple, direct way. When we win the interest of a group of contributors, we should find a way to keep this interest at least by giving the group more and more information or preferably some active work to do for the home—perhaps working for social legislation that is needed in our field. Interest will not stay alive or grow unless it is nourished.

Included in community relations is the important work of stimulating research. How valuable, for example, it would be to get some research group to find out what contributions maternity homes are making to better understanding of, and so to better treatment of, the emotional factors that lead to pregnancies outside of marriage, especially second pregnancies. Do we know what contributions the homes have made to strengthening family life? What contributions have they made to the broad fields of social case work and social group work?

We also have a responsibility in community planning for health and social services. Are maternity homes supplying leaders for the efforts being made to strengthen all types of services to unmarried mothers and fathers and their babies? Have we the duty of reaching out not only to those who support these services but to the unmarried mothers who need help but do not go to maternity homes for it?

Our homes are a living part of the community in which we serve. We have learned a great deal over the years from our contacts with the young people who have sought our help. We should not let what we have learned stay in a narrow groove of service but should send it out beyond our walls to enrich the knowledge of all who are working with children and adolescents.

Reprints in about 6 weeks

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"Two hundred years of the social history of the United States—as a colony and as a republic—had woven their changing pattern into the Nation's life before protection was offered to unmarried mothers in shelters definitely for them. During the two centuries in which this new tolerance was slowly germinating, harsh punishment for the mother and denial of legal rights to her child were the general rule. The stigma placed on mother and child is an old, old story—much older than two centuries. The stigma is as old as the institution of marriage, which it is imposed to protect. Society hoped to prevent illegitimate births by the severity of its punishment and of its legal discriminations. It took no cognizance of causes or of the innocence of the child. This solid wall of illogic had to be razed. Individuals and groups who saw the role of society and the law as protective rather than punitive have made a breach."

—Maternity Homes for Unmarried Mothers; a community service, by Maud Morlock and Hilary Campbell. U. S. Children's Bureau Publication 369. Washington. 1946.

NEW LIFE EXPECTATION FOR "BLUE BABIES"

DOROTHEA ANDREWS

PROSPECTS for a longer, healthier life for the Nation's "blue babies" are being brightened by a plan to provide surgical and hospital care for these children in regional heart centers.

The first such center, now in operation in Connecticut, has been arranged with the Connecticut State Department of Health at the Grace-New Haven Community Hospital. Patients are accepted not only from Connecticut but experimentally from Rhode Island as one of the States in the region.

Other centers are being planned in the East, South, Midwest, and Southwest, and on the West Coast, to provide full geographic coverage for the entire country. The program is expected to be in full swing by 1952. The centers will serve not only "blue babies" but children with other congenital heart malformations that respond to surgery.

Despite the possibilities of the plan Children's Bureau doctors warn that it will not cure all cases of congenital heart malformation and that it will help provide care for relatively few children each year. Because of physical limitations of the proposed centers and because of lack of funds, the regional heart-center plan, even when well under way, may reach only a small percentage of the children who need the delicate heart operation.

Not every child with a malformation of the heart can be operated on for it successfully. Extensive preliminary tests are often required to determine which children may benefit.

The Children's Bureau is planning to spend $100,000 this year, beginning July 1, 1951, to foster the program through allocations to official State crippled children's agencies, which in turn pay the cost of care at the regional centers. Preliminary estimates are that surgical and hospital care and related services will cost on the average approximately $1,000 for each baby treated. This will permit meeting the needs of about 100 of these children in a year.

In 1948, 7,335 children under 1 year of age died from congenital malformations of the cardiovascular system (heart and blood vessels)—6.5 percent of the total of 113,169 infant deaths that year.

Up to a few years ago, there was little hope that "blue babies" could live very long. But the now-famous operation by which the surgeon constructs a "detour" around a partly obstructed artery has given these babies new life expectation. Operations are done for other types of congenital heart disease also, but specialists in heart surgery are still few.

Chances for success are good

A study of the first 828 patients operated upon by Dr. Alfred Blalock and his associates for congenital heart malformations between November 1944 and August 1949 shows that a child, selected on the basis of preliminary tests, who undergoes the "blue baby" operation has an 85-percent chance of coming through the operation greatly improved and an equally good chance of maintaining the improvement.

Representatives of State health agencies have described specific situations in which no facilities were available in the State to treat congenital heart malformations, and in which it was difficult or impossible to arrange for admission of the babies to centers in other States.

The State crippled children's agency will find children with congenital heart disease through its clinics or by referrals from doctors, parents, well-child conferences, or other individuals or groups.

Once the child is selected for surgery, the cost of his care at the center is financed by the best method the State crippled children's agency can devise. This may involve the use of funds made available for the regional centers by the Children's Bureau. It may be that the State agency itself has funds that can be used, or the care may be financed in part by voluntary agencies, or by the parents, if they are financially able to do so.

The home State agency makes arrangements for transportation of the child to the regional center, either through use of State, local, or Federal crippled children's funds available, or through payments by the child's parents. One or both parents, or someone who can act in their place, must accompany the child to the regional center and remain in the city with him while he undergoes hospitalization, in an effort to assure a degree of emotional stability during the pre- and post-operative period.

After the child has his operation, the center may arrange for his transfer to a convalescent home near the hospital, to stay until the doctor is satisfied that the child is ready to return home.

Finally, a complete report of the child's history at the center is sent to the home State crippled children's agency. That agency arranges any necessary follow-up, obtains medical supervision if this is needed, and becomes responsible for the child's return to the center for check-ups at 3-, 6-, or 12-month intervals, as requested by the center. In addition, the crippled children's agency in the home State may provide psychological guidance, social service, or nutritional advice to the family if needed.

Details of the first center plan have been worked out by Children's Bureau doctors in conjunction with the Connecticut State Department of Health. Dr. Stanley H. Osborn, Commissioner of the Connecticut State Department of Health, has been a guiding factor in the plan's preparation.

Dorothea Andrews is chief of the press and radio section, Division of Reports, Children's Bureau. She is a former newspaperwoman, most recently a reporter on the Washington Post.

Reprints in about 6 weeks

FOR YOUR BOOKSHELF

PROGRAMS OF THE FEDERAL GOVERNMENT AFFECTING CHILDREN AND YOUTH. Interdepartmental Committee on Children and Youth, 1951. Washington. 126 pp. Single copies 55 cents. A discount of 25 percent is allowed on quantities of 100 copies or more. Send check or postal money order to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

This 126-page book brings together, for the first time, information on what agencies in the Federal Government do for children and youth.

Prepared by the Interdepartmental Committee on Children and Youth, with members from 10 major departments and agencies, this reference book tells the story of how Federal programs developed; gives brief summaries of what the agencies are doing for the health, welfare, education, recreation, employment, protection, and housing of children and young people; and describes United States cooperation in programs for children of other countries.

ANXIETY IN PREGNANCY AND CHILDBIRTH. By Henriette R. Klein, M.D., Howard W. Potter, M.D., and Ruth B. Dyk, M.S. Paul B. Hoeber, Inc., New York, 1950. 111 pp. $2.75.

This is a study of 27 women having their first babies. It indicates that the previous personality structure of the mother gives us some clue as to the way she will feel about her pregnancy, although it does not give us any direct indication as to how she will bear the period of labor.

The report includes a good discussion of superstitions and misconceptions about pregnancy and an interesting chapter on some of the psychosomatic aspects of symptoms in pregnancy and in childbirth. One would wish that a larger study might be made, as well as some comparison with women who have had more than one child, for it is possible that the findings might be different with such studies.

The book is recommended for professional workers in prenatal clinics or in public health departments, for psychiatrists, obstetricians, and all those having an intimate interest in the psychology of pregnancy.

Harold E. Mann, M.D.

WHAT EMPLOYERS WANT. By James C. Worthy. Science Research Associates, Inc., 57 West Grand Avenue, Chicago 10, Ill. 1950. 48 pp. Single copies, 60 cents; 15 or more, 50 cents each; 100 or more, 35 cents each; 1,000 or more to one address at one time, 25 cents each.

Written for teen-agers by an employer, this pamphlet discusses what kind of workers an employer wants, and why; how an employer sizes up applicants during an interview; and what factors, in the opinion of an employer, contribute to success on the job and to advancement.

Because the beginner often has little skill or experience to offer, the employer usually pays special attention to his educational background, says the author. This helps him determine whether the applicant has the necessary aptitude to become an efficient, productive worker. And ability to get along with other people and to adjust to the demands of a particular job in terms of behavior is, in the eyes of the employer, as important for the young worker as learning the skills required for that work.

Dorothy M. Orr

TEACHING BETTER NUTRITION; a study of approaches and techniques. Prepared by Jean A. S. Ritchie. Food and Agriculture Organization of the United Nations, Nutrition Division. Washington, 1950. 148 pp. $1.50.

This bulletin attempts to supply information on the many aspects of nutrition education on which member countries of the Food and Agriculture Organization have sought help from the Organization's Nutrition Division. Starting with a brief discussion of the need for nutrition education, the author deals in somewhat more detail with organization of programs, training of workers, methods, materials, and evaluation. Throughout these chapters are frequent references to nutrition problems and activities in various parts of the world. The last chapter consists of brief descriptions of programs. Although these were chosen to illustrate different approaches to the improvement of nutrition through education, they also give an idea of the geographic scope of educational activities in that all five major continents are represented.

The introduction points out that administrators will probably make most use of the sections on objectives, organization, and training, and that local workers will refer to the chapters on materials and methods. One of the chief impressions that child-health and child-welfare workers may gain from the bulletin is that nutrition is most likely to improve through education when the educational activities are tied into some basic effort toward betterment of conditions that the people themselves wish to change.

Marjorie M. Heseltine

Calendar

(Continued from page 32)

Nov. 8. Play Schools Association. Annual meeting. New York, N. Y.

Nov. 10–12. National Conference of Christians and Jews. Annual meeting. Washington, D. C.

Nov. 11–17. Book Week. Thirty-third annual celebration. Information from Children's Book Council, 50 West Fifty-third St., New York 19, N. Y.

Nov. 11–17. American Education Week. Thirty-first annual observance.

Nov. 12–14. School Food Service Association. Annual meeting. New York, N. Y.

Nov. 14–16. National Association of Intergroup Relations Officials. Annual meeting. Detroit, Mich.

Nov. 16–17. American Academy for Cerebral Palsy. Annual meeting. Boston, Mass.

Nov. 26–30. Association of State and Territorial Health Officers. Annual meeting. Washington, D .C.

Nov. 29–Dec. 1. American Public Welfare Association. Annual Round Table Conference. Washington, D. C.

Nov. 29-Dec. 1. National Association for Mental Health. First annual meeting. Chicago, Ill.

Illustrations: Cover, Philip Bonn for Children's Bureau. Pp. 19, 22, and 23, Merriewood Day Camp, New York City. P. 20, Play Schools Association, New York City. P. 24, Library of Congress photograph. Pp. 25 and 26, National Archives.

THE CHILD

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

• CALENDAR

Oct. 1–5. National Recreation Association. Thirty-third National Recreation Congress, Boston.

Oct. 1–31. Red Feather Month. Information from Community Chests and Councils of America, 8 West Fortieth Street, New York 18, N. Y.

Oct. 3–6. National Society for Crippled Children and Adults. Annual convention. Chicago, Ill.

Oct. 4–7. Rural Youth of the U. S. A. Annual conference. Jackson's Mill, Weston, W. Va.

Oct. 8–12. National Safety Council. Thirty-ninth National Safety Congress and Exposition. Chicago, Ill.

Oct. 9–12. American Dietetic Association. Thirty-fourth annual meeting. Cleveland, Ohio.

Oct. 12–14. American Society of Dentistry for Children. Twentieth annual meeting. Washington, D. C.

Oct. 15–18. American Dental Association. Ninety-second annual session. Washington, D. C.

Oct. 15–18. American Legion. Thirty-third annual national convention. Miami, Fla.

Oct. 15-18. National League to Promote School Attendance. Thirty-seventh annual convention. Wichita, Kans.

Oct. 15–18. Girl Scouts of the United States of America. Thirty-first national convention. Boston, Mass.

Oct. 18–20. National Conference of Juvenile Agencies. Forty-eighth annual meeting. Chicago, Ill.

Oct. 20–25. American Academy of Pediatrics. Twentieth annual meeting. Toronto, Canada.

Oct. 24. United Nations Day.

Oct. 25–27. National Council of Negro Women. Sixteenth annual convention. Washington, D. C.

Oct. 29. Association of Maternal and Child Health and Crippled Children's Directors. Annual meeting. San Francisco, Calif.

Oct. 29–30. National Midcentury Committee for Children and Youth. First meeting. Chicago, Ill.

Oct. 29–Nov. 2. American Public Health Association. Seventy-ninth annual meeting. San Francisco, Calif.

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U.S. GOVERNMENT PRINTING OFFICE: 1951—952602

THE CHILD

NOVEMBER
1951

WHY DOES A YOUNG DELINQUENT RESIST TREATMENT?

HARRIS B. PECK, M.D.

ON A DARK moonless night some 2 years ago, 15-year-old Philip C tried to pry open the door of a warehouse. His efforts were rather clumsy, and the crowbar he used was ill-suited to the purpose. After blundering about a half hour or so, he found himself spotted by the headlights of a police patrol car. In his panic to escape he ran down a blind alley and was easily cornered by a policeman. Philip did not resist, and in short order he found himself before a judge of the children's court.

The officer in a bored monotone recited the details of Philip's arrest. The judge turned to him and in a not unkind voice said: "Well, Philip, you have heard the officer's report. What have you got to say for yourself?"

The boy, staring fixedly at the floor, and without even looking up, sullenly muttered: "I didn't do it."

The officer's color deepened perceptibly, and the judge became a little less kind.

"Come, boy, you were caught in the act. Lying will do you no good."

Philip paid no attention. Nor was there any significant change in his demeanor at the detention home or during the course of the probation officer's investigation. He was sullen, evasive, and untruthful in his insistent denial.

At the diagnostic service our first glimpse of Philip provided us with no easy explanation of his puzzling behavior. He was neither psychopathic nor psychotic. He had the capacity for moral judgments, the emotional equipment for experiencing feelings of guilt and anxiety, and an intelligence adequate enough to perceive that it might go worse with him if he persisted in his "uncooperative attitude." But persist he did, and in a way that seemed to promise considerable resistance to any therapeutic endeavor.

Whatever a child's neighborhood, its sights and sounds have the familiar feel of home.

Mrs. C, Philip's mother, on the other hand, seemed more helpful. She proclaimed herself ready and anxious to assist the clinic; said she had suspected that Philip had been stealing, and now, alas, he was beyond her control. Mrs. C said that she had tried hard, since her husband's death, to bring up Philip as a good boy, but despite her efforts he had begun to play hookey. But that wasn't his fault; the school was bad. It was overcrowded and the teacher took no interest in a boy like Philip, who maybe needed a little extra attention. The teacher was mean to him and that was why Philip refused to go. He wasn't

Dr. Harris B. Peck, Senior Psychiatrist, Treatment Clinic, Domestic Relations Court of the City of New York, is also a member of the faculty of the New York School of Social Work of Columbia University. Formerly he was on the faculty of the New York University School of Medicine. He is one of the founders of the American Group Therapy Association and is chairman of its educational committee.

Dr. Peck has based this article on the paper he gave at the seventy-seventh annual meeting of the National Conference of Social Work.

really a bad boy; it was just the kind of tough crowd he had gotten in with in the neighborhood. It was a bad neighborhood. She would like to move out, but what could she do on a relief budget and apartments so hard to get? Nevertheless she would be glad to cooperate in any way the clinic wanted her to.

I have tried to sketch for you the bare outlines of the sort of case familiar to any agency that sees delinquents and their parents. Even with such meager information as this, the skilled worker might well hesitate to accept the C's for treatment. An agency that attempts to select persons who seem most capable of utilizing its therapeutic services might well be concerned about the difficulties likely to be encountered in the course of treatment for either this boy or his mother. The boy, by denying what he did, certainly offers little basis for a relationship designed to explore either his present difficulties or his other life problems. His mother, ostensibly so anxious for help, is overprotective of her son and at the same time denies all responsibility, placing it on schools, teachers, relief, and so forth. Much of her story is undoubtedly rooted in truth, but she is using it to evade any involvement in her son's treatment.

If an agency accepts a case such as this, it is likely that both mother and child will frequently miss appointments; that the mother will adhere tenaciously to externals; that the boy will enter upon prolonged sullen silences and will probably continue his delinquencies. Such a case might well be considered unsuitable for treatment by the judicious intake worker, who discerns the strong defenses that the mother sets up in denying her role in her son's difficulty and the boy's seemingly irrational protestations of innocence. The resistances —we say—the resistances are too great.

It isn't only boys that have a sense of belonging to their block; girls have it too.

I have begun to suspect that if in saying this we refer only to the defenses against treatment that exist in the patient's unconscious, our statement is only half the truth. For I am coming to believe that we cannot speak of the resistance of people like Mrs. C and her son without at least examining the resistance in ourselves if we assume the responsibility of being helpful to them.

I will not quarrel with those who prefer to examine these questions in terms of the inflexibility of certain of our treatment agencies in their approach to the delinquent and his family. An analyst, on the other hand, who encounters frequent failures with certain types of patients does not hesitate to search for inner resistances within himself, which he may suspect of being at least partly responsible for certain of the obstacles encountered in treatment.

When I speak of the resistances that are present in both agency and client in the field of delinquency, I refer to certain defects in our approach to the delinquent, which seem to be almost deliberately contrived to foster rather than to resolve the problems of inaccessibility so noticeable in the delinquent and his family.

The relation between delinquency and deprivation is reflected in the high incidence of delinquency in community areas that lack adequate housing, school, recreation, or medical facilities. In the treatment of individuals the plan is not formulated on the basis of symptoms but rather in terms of the underlying dynamic needs. So as we progress in our understanding of the complex relation between the individual delinquent and the defects of the community, we must inevitably move toward remedying these defects rather than continuing our fruitless attempts to resolve an unending series of critical situations.

By the time the delinquent's disturbance has progressed so far as to bring him into trouble with the neighbors, or the school, or the police, he usually shows a marked distortion in his relationship with authority. Authority is brought close to him not only by a judge or a probation officer, but even by the seemingly friendly and well-disposed case worker who sits across

the desk smiling her most permissive smile. It seems, then, like asking for unnecessary trouble to attempt to approach the delinquent in settings that are likely to bring on almost invincible resistances at the very outset of treatment.

Workers have recognized for some time the therapeutic advantages to be gained in meeting the delinquent at places to which he comes spontaneously and where his initial encounter is with people not associated with his unpleasant experiences with authority. Our experiences in the use of group therapy as a method of treating delinquents and their parents at the New York City Court of Domestic Relations lead us to believe that most children are better able to tolerate adults when they have the support of a group of other youngsters. A group tends to dilute the intensity of face-to-face relationship with an adult, a situation which is sometimes unbearable to children with critical disturbances in their relationship with authority.

Such thinking about treatment approaches may well be irksome to persons who have already attempted to meet the problem of delinquency within some of our traditional community and group-work settings. They point out, and correctly, that the persons most in need of attention are precisely the ones who are apt not to be helped at a playground, a community center, or a parents' discussion group. The families that ultimately appear in court are likely to be the ones that do not attend such agencies, or if they do come, may drop out or even be forced out because they are disruptive elements within the groups usually available to them. This problem, however, is not an insoluble one unless we permit our resistances to make it so.

For if we agree that we ought, wherever possible, to change the kind of settings in which we treat delinquents, to move from the formal confines of the court or traditional case-work agency to the community center, playground, hospital clinic, vocational agency, then we, who are especially qualified to give treatment, cannot at this point wash our hands of the whole business. We cannot say "This is not our job." We cannot justify our deserting the delinquent, with the excuse of poor outlook, until we have taken the necessary steps to reduce the large number of treatment failures in this field. Our failure to take these steps is a symptom of our resistance against extending ourselves beyond the habitual patterns, the traditional confines of our agency structure.

Thus, the delinquent, who is so often the scapegoat of the disturbances within his family, is forced to bear a double burden. He not only suffers for the community's failure to provide satisfactory resources to help him grow and develop normally, but in addition he is rejected and neglected in the distribution of services required to repair the damage already done to him.

If this state of affairs is to be altered we shall have to begin now to revise drastically many of our present ways of approaching delinquents and their families. I believe it is essential to any such revisions that we stop regarding the delinquent as someone whom we must keep from doing an undesirable act. Rather our emphasis must be on providing services within certain areas of our community with a view to meeting the needs of deprived individuals within such areas. Agencies whose operation seem to be dictated by policies of "sit and wait — let them come to us," must critically reexamine their attitudes. We have already discarded such attitudes in the field of education and public health, and they most certainly have no place in a comprehensive community program against delinquency.

Such a comprehensive program is envisioned in the work of the New York City Youth Board. The functioning of this agency is unique in a city remarkable for its vast conglomeration of private and public agencies. The basic premise on which it operates is an acceptance of community responsibility for providing for the unmet needs of children — not only children who get into trouble, or children whose parents ask for help, or families who are "accessible" to treatment — but merely children with unmet needs.

A significant characteristic of the

(Continued on page 43)

Neighborhood activities, good or bad, mean much to the youngsters who take part in them.

MICHIGAN LOOKS TOWARD COORDINATING ITS WORK FOR CRIPPLED CHILDREN

Physical and occupational therapists meet with other professional workers to discuss joint problems

JESSIE F. WADDELL
MARY A. BLAIR

MICHIGAN occupational and physical therapists have taken a long step toward bringing together the many types of professional workers who serve crippled children.

Members of these two groups joined in a State-wide conference for the first time 2 years ago, and met again last year. In 1951 they progressed to the point of including in the conference some others who work with crippled children—physicians, teachers and school officials, nurses, social workers, and speech therapists — to discuss with them a closer coordination of the various types of work they do for the same patients.

To coordinate services

At all three conferences the members discussed not techniques of actual services for crippled children, but rather how to make such services more effective. They sought ways to promote continuing service after the child's discharge from a hospital.

They urged that everyone concerned learn more about the resources that can be used to help a child in his own community. They compared methods of obtaining equipment for use in functional training for crippled children, and of keeping this equipment in repair.

They made suggestions for recruiting young people for occupational and physical therapy, in an effort to overcome the shortage of therapists that intensifies many of the other problems discussed. They exchanged views on achieving closer relations among all professional workers in fields concerned with children.

How did physical and occupational therapists get this chance to ask the questions that demanded answers and to work out suggestions for united action in local communities? They long had wanted some way to discuss their day-to-day problems together. But a gap separated occupational therapists from physical therapists, although they have similar perplexities. Each specialty had for years held its own professional meetings; but no interprofessional meetings came about.

Realizing the need, the Michigan Crippled Children Commission, the official State crippled children's agency, took constructive action. Along with the State Department of Public Instruction, it arranged for an interprofessional meeting in 1949, for an interchange of ideas. This led, step by step, to the 1950 and 1951 meetings. The Michigan Society for Crippled Children and Adults and the National Foundation for Infantile Paralysis assisted the two sponsoring agencies in their project.

Because the meetings were planned to be informal, the setting chosen for the whole series was a rustic lakeside lodge in the woods of Northern Michigan. The State Conservation Department maintains this lodge for in-service training of its staff, and makes it available for meetings of this kind.

Members of the first two conferences of the series, held in 1949 and 1950, were (1) staff members of the sponsoring agencies, (2) occupational and physical therapists who work in local communities throughout the State, (3) therapists from schools and convalescent homes, and (4) representatives of other State-wide and local agencies dealing with services for crippled children. The 1951 conference included also members of the other professions whose skills serve crippled children.

In order to have the necessary consultant services available when the discussants needed them, the sponsors arranged for specialists in various professions to come to the meetings as advisers. Their expenses were paid by the Michigan Crippled Children Commission. At the 1949 meeting the advisers were (besides the staff members of the sponsoring agencies): The medical director of Region V, Children's Bureau, of the Federal Security Agency; a member of the Joint Orthopedic Nursing Advisory Service who is now polio consultant of the American Physical Therapy Association; the director of the Bureau of Ma-

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ternal and Child Health of the Michigan State Department of Health; the chief physical therapist of the Sigma Gamma Hospital School, a convalescent hospital; and a college instructor who has had experience with the processes of group dynamics.

The leader in group dynamics was there to introduce the conferees to a way of discussion that makes it possible, in fact necessary, for all members of the conference to take an active part in the organization of the meeting and an articulate part in the discussions, a way that is intended to make them practical, definite, and fruitful.

At the suggestion of the leader, the members divided into random groups of about seven each, and elected a chairman and a recorder. After the small groups had defined the problems they wanted to discuss, the recorders met and listed the problems in suitable classifications, and presented them to the conference as a whole. Then the members of the conference regrouped themselves, each one joining the work group that was to consider his particular set of problems. Each work group elected an observer, as well as a recorder. This observer, as a member of the work group, looked at its work objectively, and later reported his observations to the conference.

This method of discussion was used in all three conferences. Each of the first two had about 50 members, but the third, enlarged to include other professions, had 67 members. A fourth conference is to be held in 1952, again drawing its members from various fields of work for crippled children.

What volunteers can do

Each year the discussions centered around the problems of "O. T.'s" and "P.T.'s" and how they can work toward solving them. The other professional members of the third conference made suggestions about this from their own points of view.

Here are some of the subjects that were considered, and a few of the suggestions made in the course of the discussions:

How to make the best use of volunteer service was one topic. The discussants agreed that volunteers should be selected carefully for their skills and reliability, and that they should do supplementary work only, under the close supervision of a therapist. Before they start, they should receive training for what they are to do.

In "O.T.," volunteers can be selected from groups familiar with craft work, members suggested, such as scout leaders, home-demonstration agents, hobbyists, art teachers, and Red Cross craft workers. In "P.T.," volunteers can be chosen from physical-education instructors, inactive nurses, and Red Cross nurse aides. These prospective volunteers should be found and listed in each community.

Other volunteers, without the qualifications of those just mentioned, might give recreational service to children with minor handicaps. They could be chosen from outstanding men and women who are interested in offering their services because they are already connected with some social or health service for children, usually as members of boards of directors. They must be willing, of course, to accept instructions and advice about their work from the therapists.

Homebound children get a chance for fun

Businessmen's clubs in many communities have shown interest in giving crippled children who are homebound opportunities for fun, some members pointed out. These volunteers give picnics and parties for the children; they arrange trips and camp outings. They supply tickets for ball games or the movies, providing the transportation necessary. They may supply severely disabled patients with machines for book projection. Members of these clubs may go to the children's own homes to play games with them or to show them motion pictures.

Running through many of the discussions was the thought that occupational and physical therapists should strengthen their lines of communication with those they work with — particularly with physicians and parents. A few ways to do this were mentioned, as, for example, by helping interns, through staff conferences, to become aware of the services that physical and occupational therapists are prepared to give, and by being careful not to assume responsibility beyond their professional competence. Therapists could inform parents, it was said, of the services that public funds provide for crippled children. This could be done through various mediums.

This little boy should continue to have physical therapy without a break until the doctor discharges him, that he may benefit fully from the skilled care he has received so far.

As soon as Ruth left the hospital, her physician gave the occupational therapist orders for helping her to develop certain muscles. The therapist sends him regular reports.

One work group considered how to improve the follow-up by physical and occupational therapists of children who have had acute poliomyelitis, so that the children get therapy sooner and more continuously. Some members suggested that therapists inform the medical profession of the services available from therapists in the local communities throughout the State, and that therapists get into contact with each child's physician at regular intervals to report the child's progress. Other members wanted the therapists to ask that specific orders from the physician who is discharging a child be transmitted through established hospital channels to the therapist who is to work with the child. (Since the conference, a form has been worked out on which the National Foundation for Infantile Paralysis reports to the Michigan Crippled Children Commission the discharge from the hospital of children with polio whose care has been financed by the Foundation.)

One very practical question became the subject of a year's survey. The question was: Where and how can physical therapists get the "P. T." apparatus and equipment needed for individual children in order to start therapy immediately after receiving the physicians' orders? The work group decided not to try to make suggestions on this at the conference, but to keep the group intact and to continue to search for information. It planned a survey to determine the need for pooling equipment and to find out what equipment is being used and what patterns and ideas for equipment are available. The therapists were to do this work with the help of physicians and engineers. The aim was to find out about adjustable prefabricated apparatus that would be reasonable in cost.

When the therapists wondered what they could do to improve coordination of services for crippled children in a community, they received these suggestions: You should affiliate with the council of social and health agencies in the county or other community in which you work. In addition, you can arrange for meetings with members of allied professions. To make discussion with these workers practical, it is good to begin with the case of one specific child, the group agreed.

The question that comes up in almost every professional discussion of making services more effective did not fail to come up here: What can we do about the extreme shortage of qualified therapists? How can we increase the number of "O. T.'s" and "P.T.'s" in civilian service? Among the suggestions the work group made about this problem were these:

In order to get more young people interested in occupational and physical therapy as a career we should reach junior and senior high-school students. We should make contacts with superintendents of schools, school principals, and especially with school vocational counselors. These counselors should be informed about all phases of the qualifications necessary for entering the work.

Therapists can help to develop recruitment teams made up of staff members of hospitals, schools, clinics. These teams would work to get information to young people about to decide on their technical training after graduation from high school. "Career days" in high school are an excellent opportunity for such teams to get their message heard.

To give young people a chance to see in action the work they are hearing about, some hospitals, clinics, and orthopedic schools might arrange to show the work in operation to a group of students.

Scholarships bring recruits

Therapists, it was suggested, should collect copies of printed matter describing their occupations and distribute them to schools and to public libraries. In addition to making the most of informational material already prepared, they should work toward having a film made for the purpose of recruitment.

Establishing scholarships for the training of young persons in "O.T." and "P.T." is a sound long-term method of recruitment.

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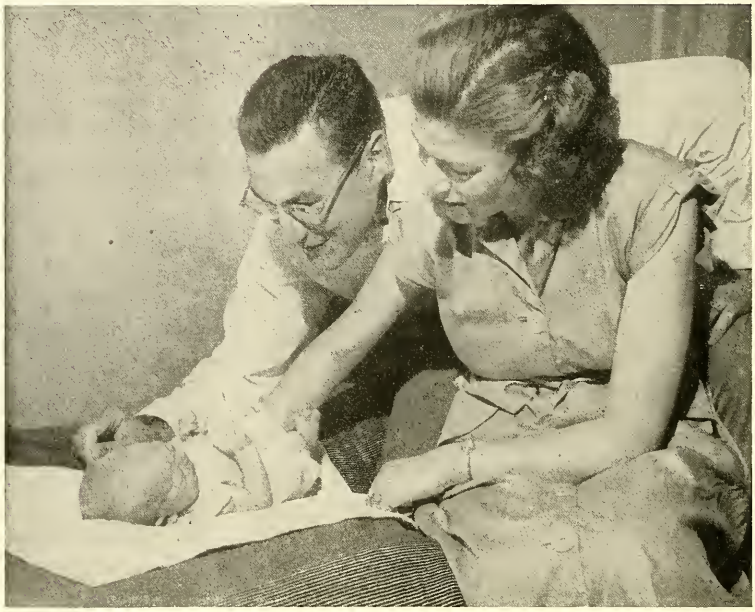
IF A BABY IS TO BE ADOPTED

How early should we place him in his new home?



MARY ELIZABETH FAIRWEATHER

FEAR of the unknown is a basic human characteristic of which case workers practicing in the adoption field have their full quota. Constructively used this fear can be a powerful incentive to careful study of the child, the natural parents, and the adoptive parents, which will transform the unknown to the blessedly secure known. Used otherwise, it can inhibit further learning.

As understanding of case work increases, generously supplemented by expanding knowledge in related fields, we who work in the field of adoption realize better, and have more respect for, the responsibility we assume in taking part in the permanent uniting of human lives. This respect is wholesome and necessary. It helps us to recognize dangers, and it convinces us of the necessity for greater exploration of unknown areas.

As a result of our sobering realization of the tragedies that can stem from badly put-together lives we have tended to remain within the protection of tested and tried methods, bolstered by all the scientific information at our command. This, too, is good in a profession that recognizes its youth. But if we are to grow, is it not high time that we take stock of the things we already know, face honestly what we do not know, and move together toward greater enlightenment by carefully observing our experience, our experiments, and their pooled results?

Inevitably, adoption practices are now uneven. Some of us have hewed closely to conservatism; others already have begun pioneering. The resources at our command are not evenly distributed, but our concerns are the same.

Let us take a glance at some of the territory we have covered and then let us train our sights on the country ahead. We may be sure that in any forward journey we

shall have valuable companions. There are psychiatry, pediatrics, and psychology, with their growing knowledge of human personality and of healthy, maturing growth, and their tested standards for various stages of development. There are sociology and anthropology, with their contributions to the understanding of cultural patterns.

We can all think of others; but let us not forget our most vitally interested contributors, our adoptive parents. And let us not forget, either, the contributions of those unwelcome but ever-present attendants, the independent and — yes— the "black-market" practitioners. They, too, can teach us something by making us ask ourselves why so many unmarried mothers, and couples, who wish to adopt a baby turn to them.

Adoption workers influence human lives

Historically, social work has been concerned with the needs of the individual in relation to his environment. For many years our efforts were confined largely to our attempts to manipulate the environment to the greater advantage of the individuals about whom we were concerned. This is, and will continue to be, a major and respected responsibility of social work in general, and case work in particular.

Gradually, however, as psychiatric knowledge is applied more and more, we are learning about the effects of inner stresses upon the individual, and on his reaction to his environment. Our diagnostic skills are of necessity focused upon recognizing both inner and outer stresses, and their causes.

In no other aspect of social work does the case worker have such unlimited possibilities for selecting the environment of an individual as does the adoption worker. And if we believe that the personality, with all its emotional components, is largely shaped by the environment that nourishes it, then in the early placement of infants we must see an opportunity for skilled case-work services that is almost overwhelming in its significance.

It is, of course, this power to influence the lives of human beings that scares us and sends us scurrying for all the support and assistance our own and related professions can give us. Again, it is well that we are scared. It is well that we view this responsibility humbly and with awe. It is well to the degree that it produces in us an unquenchable thirst for greater and deeper wisdom upon which to form our judgments and discharge our responsibilities. It is well to the degree that it drives us to keener observation of facts, so that from pooled experience we can form a whetstone on which we can continually sharpen our skills. It is not well if this same fear reduces us to immobility and the overcautiousness that keeps us from careful experimenting and the ability to learn from it; if it blinds us to the significance of new knowledge in our own and allied fields.

For purposes of this discussion I should like to consider "early placement" as meaning placement of babies under 3 months of age. We know that comparatively few of our agencies are placing babies younger than that. Why? Because they know of families that accepted infants shortly after birth and have subsequently found that they had serious physical or mental impairments. This not only has given us cause for thought (as well it should) but has stopped some of us in our tracks with what appears, occasionally, to be permanent paralysis.

Because of those unfortunate placements we have wisely sought more careful and accurate advice from medicine and psychology. But have we always made full use of this advice? Medicine, for instance, tells us that there are comparatively few serious physical abnormalities at birth that cannot be detected in the first few weeks. Perhaps we have given undue weight to those comparatively few possibilities. We know that psychology is making rapid strides in testing. Are we keeping up with the psychologists?

Knowing full well the dangers of blind placements, we have looked down our noses at those who make them. Struggling to offset the evils of such placements, we have brought fear psychology to bear in appealing to the self-interest of couples who wish to adopt a baby, by saying: "Come to an agency so that you can be assured of mental and physical adequacy in your child!"

What causes adoption failures?

Can we ever really guarantee this? And if we could, is this, or should this be, the primary function of sound adoption practice? And has this stopped or even slowed up the black-market and independent placements? The answers are all too clearly written, first in the statistics of adoption courts, and later in adoption failures recorded in family agencies, guidance clinics, juvenile courts, and mental hospitals. Are these failures due to mental or physical inadequacies of the child? Not predominantly. They are due usually to inadequate parents or inadequate help in the adjustment process.

Is it not time that we put our emphasis on other areas of our knowledge and concerns? Listen again to some of our other sources of advice: to psychiatry, to our own experience, to the adoptive parents themselves.

There is a triangular motif that runs through the design of all human life. Freud and his disciples point up its outlines in tracing the dynamics of emotional growth. Helene Deutsch, in her study, "The Psychology of Women," discusses a

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Before concentrating on adoption work Miss Fairweather had many years of experience in the general field of foster-care placements and in the child-protection field.

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This article is condensed from a paper Miss Fairweather gave at the seventy-sixth annual meeting of the National Conference of Social Work.

woman's profound need to love her child in a family triangle. Whether balanced or distorted, this triangle influences every psychiatric consideration of human experience from infancy to the grave.

In a sense, adoption practice is framed by another triangle, with the child as the apex and with the sides made up of his own parent or parents, the adoptive parents, and the agency. We have had the apex under the microscope for some time now and this is well, for we still have much to learn. But I suggest that if the apex is to be supported adequately the sides must be kept in balance and strengthened by our understanding.

We learn from other fields

Reiterating my appreciation and admiration for what psychology has contributed, and promises to contribute, to the field of adoption, I believe we need to make careful use of everything it can offer and to be fully alert to its continuing contributions. But what of our other obligations? What of our other counselors?

What, for instance, does psychiatry tell us about early infancy? There is as yet no complete agreement about the significance of constitutional factors in the development of personality, but no one underestimates the influence of environment on these factors. I do not need to remind you of the constantly mounting studies that show the influence of family relationships from the moment of birth and the role that consistent mothering plays in the optimum development of the infant, not only physically, but emotionally and mentally as well.

Dr. Margaret Ribble, in "The Rights of Infants" points up the importance of the first 3 months of life in this respect and the damage that can be done to a child if mother love is lacking. Dr. Leo H. Bartemeier and his associates, who formulated the idea of the Cornelian Corner, emphasize the advantages of earliest possible mother-child relationship. Doctors Arnold Gesell and Catherine S. Amatruda, in "Developmental Diagnosis," point out that children in faulty homes and in institutions are often retarded. Many psychologists expect children brought up in institutions to rate lower than their true potential levels. This is shown when the child is tested again after adoptive or foster-home placement. We have abundant evidence from our own experiences of how children who have been severely hurt emotionally can blossom if they are given love and security. We can and should obtain more scientifically compiled evidence of this, which is well known to every adoption worker. But we can never hope to measure how much more might have been attained if the hurt had not occurred.

We know that the very circumstances that make a baby available for adoption fill his earliest environment with conflict and rejection. We know how adequately and joyfully an adoptive couple, capable of healthy parental feelings, can meet a baby's needs in a way that is beyond anything we can hope to offer through other kinds of foster care.

First adjustment is all-important

Looking at the adoptive parents, psychiatry underscores our conclusions by recognizing the importance of the complete dependency and helplessness of the very young infant as a factor in laying firm foundations for parental feelings in the adoptive family. We know the injury that change can cause to a child, and its effects upon his adjustment even in a happy placement. We know the disturbing effect a child's difficulties in eating, sleeping, and so forth, have upon adoptive parents, particularly the mother, and the vicious circle this can set up in the all-important first adjustment. This has urgent significance, not only in planning for early adoptive placement but, where this is not possible, in planning for individualized rather than group care for infants.

Listen to applicants for a baby to adopt. "How early do you place?" "We want as young a baby as possible." "We are not afraid of taking some risks; we'd take some risks if we had a baby born to us."

Look at the throes of "psychological labor," always present at the time of placement. Aren't they lessened by the aspect of a young and helpless infant whose features have not developed the distinctive characteristics that have to be reconciled with those of the omnipresent fantasy child?

The coming of a child into an adoptive family has been described as a rebirth. This is not just a figure of speech. It has deep psychological reality. The birth pangs for both adoptive parents and child are notoriously greater in direct proportion to the age of the child.

Listen to adoptive parents who have had their baby from the first few weeks of his life: "Already he seems like ours. We know we can help him develop his personality as well as his physical powers and in that sense we are creating him and he is really ours."

Look at the majority of children placed by "black markets" and independent agents. In what age group do they fall? Infancy, of course. Why?

But what about protection? Well —what about it? Whom are we protecting by delaying placement? Is it the child, who is our paramount responsibility? According to psychiatrists, no. Is it the adoptive parents, whom we have chosen because of their indications of maturity, good life adjustment, and mutual happiness? Not usually at their request. Is it the child's own parents (frequently the unmarried mother), who have not found a more ready and willing answer through the "black market" or other independent sources? Psychiatric and our own case-work literature are filled with warnings of the neurotic conflict that may result from delayed decisions.

Here, again, is the adoption triangle. Our responsibility for protection lies within it, but that responsibility is not usually discharged

in the best way by delayed placement of the child. When careful social diagnosis indicates adoption for an infant, we must remember that the welfare and protection of all concerned are inextricably interwoven. And I believe that their best interests are served by the earliest possible placement. Let us concentrate less on our fears of unknown factors in a child and try harder to develop greater ability to know our adoptive applicants and to realize what they can offer as healthy, nutritive soil in which a new life can develop. Normal, well-adjusted adults, given the opportunity, can weigh the risks of reasonable unknowns, arrive at a decision, and find a healthy way to adjust to the results of their decision. Basic case-work principles proclaim that the adoptive parents have a right to this kind of self-direction. If our professional evaluation has been sound we have no need or right to overprotect them.

Our energies might be spent to better advantage in careful case-work services to natural parents in helping them reach an early and clear decision when adoption is indicated; in helping them to give as complete and accurate information as possible about their babies' backgrounds as one of their contributions to this plan. Between the natural parent and the child placed for adoption there is a psychological as well as a physical cord to be cut. If it isn't carefully and skillfully cut at the appropriate time it can be a permanent threat to the security of any adoption placement.

We must know ourselves

And our energies might be spent better in looking at ourselves. Are we making full use of the professional knowledge and advice available to us? Are we training our workers to know the boundaries of normal development in children so that their observations can supplement and assist those of our consultants? Have we the courage to discharge the responsibility we have assumed? Or must we share our doubts and fears of the unknown as well as our knowledge of pertinent facts? Have we the courage to face squarely our inevitable areas of inadequacy? And can we derive from them the stimulation for increased efforts to widen and deepen our knowledge and for greater sharing of the results of our efforts?

I recognize that there always will be situations in which delays are inevitable. We shall always have the older child to place. That is another topic and a challenging one. But when we can, let us place the baby early. Let us by all means make use of every available tool to increase our knowledge and to guide the adjustment of child and family. Where justifiable doubts are present, let us have serial tests made.

But why can't these tests be done more often in the adoptive home, with adequate preparation and interpretation given to the parents? Why would it not be feasible some day to have psychological tests given to all babies as are physical examinations? Why cannot these tests be viewed as an early step toward vocational guidance rather than as a measurement of abstract adequacy? Do not healthy, well-adjusted parents want primarily the optimum development of their children within their capacities?

Science indicates that individually our maximum capacity for mental development is fixed at birth, but that our chances for achieving it are modified by our later environment. We now believe that even intelligence quotients can be raised, in an adequately supportive and stimulating climate. Those of us in adoption work have held front-row seats at many of these performances. We have evidence that emotional quotients have no such prenatal roots. Fortunately, high intelligence quotients and high emotional quotients are not mutually exclusive; but neither are they necessarily correlated. We in adoption work are today selecting the soil that will nourish many of tomorrow's emotional quotients. Here at once is the adoption worker's deepest responsibility and greatest challenge.

Reprints in about 6 weeks

DELINQUENCY

(Continued from page 36)

Youth Board has been the intimate interrelationships that it has evolved in its work with a great variety of widely differing agencies. Recognizing that delinquency is not a single problem but rather a complex of problems, with aspects in the fields of health, welfare, psychiatry, group work, and education, the Youth Board has not hesitated to call upon any resource in the community that touches its job of providing services for children whose life situations are thrusting them into delinquency. This has meant a considerable broadening of the case-finding process. Also, the Youth Board's research into area distribution of delinquency calls for obtaining involved and detailed knowledge not only of the statistical, but also of the cultural, variations among the various areas of the city.

The Youth Board's approach has emphasized that the intake process is also a reaching out. The concept of reaching out should be an essential part of any program that offers treatment services to people whose previous experiences have intensified their feelings of defensiveness and suspicion toward those who ostensibly are interested in helping them.

All of us must be sharply aware of the tremendous advantage enjoyed by a worker who is able to offer service in a way that is acceptable to the client. The experienced case worker is aware that one may visit the client's home, community center, or neighborhood without seeming to intrude, if one acts with a real respect for the integrity of the client, and if one is prepared to assume the responsibility of offering the kind of substantial services implied in such overtures. These services must not only be nominally available but actually accessible to those who might require them.

I believe that an approach of this kind may also carry with it a pos-

sible solution to some of the problems of obtaining adequately trained personnel to meet the increased burden thrown upon available treatment resources by any such comprehensive program as that of the Youth Board. I believe the step we should take is to transfer the functions of selected treatment personnel to community agencies such as schools, playgrounds, and community centers, in high delinquency areas.

If such personnel are used both in participating and supervisory capacities it may be possible to add to our treatment resources in a way that may be more effective and economical than merely creating new treatment agencies, remote from the settings accessible to our prospective clients.

I understand that the New York City Youth Board is studying the possibilities of further development of its program in this direction. If this can be brought about, we may, for example, be able to introduce therapeutically oriented services into a parents' group at the school attended by young Phil C, whom you met at the beginning of this paper. It might be possible then to bring his mother into treatment without bringing on her resistance. And it might then be less important for Mrs. C to shift the entire blame onto the defects in her life situation.

As for her son Phil, can there be much doubt that he would be more responsive if approached within his neighborhood by a worker who is part of that neighborhood? And could we not provide for him a classroom experience guided by a teacher similarly oriented?

Are we the ones responsible?

Such arrangements are not easily made, and yet unless we make provision for them soon we shall have to acknowledge that when a boy like Phil insistently denies his guilt, he may be right. Perhaps **he** did not do it and maybe **we** did. It is just possible that it is about time **we** started doing something about it.

Reprints in about 6 weeks

CRIPPLED CHILDREN

(Continued from page 39)

A teacher in the group said that therapists, like others whose work is not well known by the public, can lay foundations for recruitment while working on their own jobs. A good piece of work can make the patient, his family, and his friends a potent source of enthusiasm that may direct vocational interest toward this field.

One member suggested that if each practicing therapist would make herself responsible for bringing one young person into her field as a trainee, the number of recruits would be considerable, and they would start with a good idea of what to expect from such a career.

Problems that therapists encounter when they work with crippled children in school were threshed over. How can these children be assured the physical or occupational therapy they need? This question was asked in one of the groups. After considering the question, the group urged that full instructions from the physicians for treatment be in the therapists' hands within 2 weeks of the child's admission to school.

When crippled children go to school

Have therapists a responsibility about the program in an orthopedic school? Yes, the group thought. Therapists should take part in planning the whole school program if "O.T." and "P.T." are to be properly integrated in the children's schooling. Furthermore, they should attend regular staff meetings and should take part in the work of school committees. Case conferences might be held, the group felt, with all staff members present who are interested in the problems of the child to be discussed. If the best possible school program is to be worked out for a child, information about him must be pooled from all sources, that is, from all who are concerned with his care or his education.

That parents of children in orthopedic schools at times need reassurance from outside the home to help them play their part in restoring the child to health, was also discussed in this same work group. The group suggested that the parents come with their child when he enters school, to learn the school set-up; that parent-teacher conferences be organized and also institutes for fathers and mothers, which parents and child may attend together. If necessary, visits can be made to the home for the purpose of getting in closer touch with the mother and father. These visits may be made by any of the professional workers concerned with the child.

The group suggested also that clubs be organized for mothers and fathers of children with special difficulties, such as cerebral palsy, and that open-house demonstrations be held for parents, so that they can see treatments in progress.

Joint discussion proves helpful

At the end of the third conference, the members looked back to see whether they had benefited from the series. They saw that they had grown somewhat in ability to take an active part in discussion and in arriving at conclusions. But their greatest gain had been in achieving some closer relations. The therapists tended to isolate themselves less as "O.T.'s" and "P.T.'s". All the members of the conferences came to feel that they were parts of an alliance, working with a common aim, even though their services to crippled children were distinctly different. School people, for example, came to understand much better the problems of a handicapped child in his home, and other specialists learned about what is done for him in school.

This series of conferences for occupational and physical therapists was, of course, based on the services for crippled children in one State only, Michigan, but the idea of the conferences could be adapted to the plans for this program in other States.

Reprints in about 6 weeks

IN THE NEWS

To uphold child labor standards

All employment of minors on military installations shall be in compliance with State and Federal labor laws. This is the policy of the Defense Department, as restated August 1, 1951, in a memorandum from Assistant Secretary of Defense Anna M. Rosenberg to the Secretaries of the Army, the Navy, and the Air Force.

This action was taken after discussion between representatives of the Department of Defense and of the Department of Labor's Bureau of Labor Standards. The latter had received a number of complaints from State labor departments to the effect that children were being employed on military installations contrary to State child-labor standards and that this employment was interfering with their school work.

The memorandum from the Assistant Secretary of Defense pointed out that the health, education, and well-being of children on military installations and reservations is a responsibility of the Department of Defense, to be discharged by commanding officers. This responsibility includes obtaining assurances that employers on such installations and reservations will comply with Federal labor laws and with State or other governmental labor laws that would normally apply except for the fact that the area is under Federal jurisdiction.

This means that Federal and State labor laws are to be observed in the employment of children in all activities at military installations or reservations, including, for example, work for concessionaries, officers' messes, military and civilian clubs, commissary stores, exchanges, motion-picture and recreational services, and groups engaged in the sale and distribution of newspapers and candy.

The Secretary of the Army, in a memorandum of August 9, 1951, has reminded all commanding generals of this policy and of his desire that they extend full cooperation to State and other officials who bring to their attention any child-labor problems.

The Bureau of Labor Standards has advised State labor commissioners of this restatement of policy and has suggested that they deal directly with the commanding officers with regard to any child-labor problems that may arise in connection with work on military installations and reservations in their States.

Interagency conference studies personality

At the request of the Federal Interdepartmental Committee on Children and Youth, the Josiah Macy, Jr., Foundation sponsored the Interagency Conference on Healthy Personality Development in Children, which met at Princeton, N. J., September 21–25. At this conference members of the Interdepartmental Committee met with outstanding social scientists, psychologists, psychiatrists, and physicians to consider the implications of White House Conference findings for Federal programs concerned with children and youth.

Co-chairmen of the conference were Dr. Frank Fremont-Smith of the Foundation and Katharine F. Lenroot. Miss Lenroot will edit the report of the proceedings.

Midcentury Committee moves to New York

The National Midcentury Committee for Children and Youth, which has been located in the Federal Security Building, Washington, D. C., is now at 160 Broadway, New York 7, N. Y.

The committee is a Nation-wide voluntary organization created to work toward achieving the objectives of the Midcentury White House Conference on Children and Youth.

More crippled children served

About 215,000 children received physicians' services under the State crippled children's programs during the fiscal year ended June 30, 1950, according to preliminary estimates. This number is 18 percent greater than the number that received such services in the preceding fiscal year (181,000), which in turn was 17 percent greater than the figure for the year before that.

The physicians' services were given in clinics, hospitals, convalescent homes, and elsewhere, mainly in a physician's office or the child's home.

The children who received these diagnostic or treatment services from physicians during fiscal year 1950 were also served by nurses; medical social workers; nutritionists; physical, occupational, or speech therapists; and other personnel making up the "medical team" for a crippled children's program.

In each of the 3 years some children not included in the counts given above received services from one or more members of the medical team but were not seen by a physician. In the fiscal year 1950 there were an estimated 30,000 such children. Taking these into account, the total number of children who received some professional services under the crippled children's programs during 1950 was about 245,000. The corresponding total counts for 1949 and 1948 were, respectively, 207,000 and 175,000.

Most of the 215,000 children who received physicians' services in 1950 were seen at clinics at some time during the year. Averaging two visits each, 180,000 children visited clinics. It was clinic services that accounted for most of the increased number of children served by the program in 1950. Almost 30,000 more children attended clinics in 1950 than in 1949, which in turn had shown a 20,000 increase over 1948.

For child health in Asia

A $20,000,000 program to improve the health of the children of Asia—half of all the children in the world—is now being conducted by United Nations International Children's Emergency Fund (UNICEF).

An antituberculosis vaccination program is well under way; on-the-ground training is being given to local child-care workers; malaria-control projects are now progressing in India, Pakistan, Ceylon, and Thailand; and nutrition demonstrations are being carried out in the Philippine Republic.

UNICEF's contribution of $20,000,000 will be more than matched by the governments of the assisted countries, for they will bear most of the cost of operating the programs. UNICEF's contribution will be used mainly for supplies and equipment.

Medical center offers service for adolescents

A special unit for adolescents has been established by the Children's Medical Center, Boston, with Dr. J. Roswell Gallagher in charge. For several years the staff of the center

has recognized that there is a need for special medical service for adolescents, who usually are cared for in surroundings intended primarily for younger children or adults. In initiating facilities for the exclusive use of adolescents the center will provide for these older boys and girls the sort of special attention that it gives to infants and young children.

The staff of the center and all its laboratory and research facilities will be available for the care and study of this age group and its special problems. Hospital care, outpatient service, and consultation service on all types of illness will be provided. The unit will give particular attention to the conditions and problems that are most troublesome in the adolescent years, such as contagious diseases, athletic injuries, psychological problems, growth, and glandular disturbances, as well as reading and other scholastic difficulties.

From the National Institute of Mental Health

Nine States have advanced to the point of having separate institutions not only for the mentally diseased but also for mental defectives and for epileptics. These States are: Indiana, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, and Texas. Most other States care for epileptics in the same institutions as mental defectives, although their needs are usually quite different. Three States care for these two groups only in hospitals for mental diseases, even though mental defectives and epileptics are not mentally ill. These States are Arkansas, Arizona, and Nevada.

About 80 percent of mental defectives admitted during 1948 for the first time to one of the 94 State institutions that reported for that year to the National Institute of Mental Health of the Federal Security Agency were under 20 years of age; their median age was 13.2 years, the girls having a slightly higher median age than the boys.

The median age of epileptics admitted to these institutions for the first time that year was 18.3 years, or 5.1 years higher than that for mental defectives. The median for girls and boys showed only a little difference in age.

A rough index of the adequacy of care provided by these institutions is the ratio of patients to full-time employees. Figures compiled by the National Institute of Mental Health show that 1948's ratio is a slight improvement over 1947's.

For interstate shipment of milk.

A decision of the U. S. Supreme Court that invalidates a provision of the local ordinance of a Wisconsin city restricting the sale of milk not pasteurized within a stated distance from the city center will undoubtedly affect other ordinances that prevent the shipment of milk across State lines.

The Supreme Court found that the city "even in the exercise of its unquestioned power to protect the health and safety of its people," cannot, by ordinance, discriminate against milk shipments "if reasonable nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available."

The Court pointed to the existence of the milk ordinance and code recommended by the Public Health Service, which, the court said, "imposes no geographical limitations on location of milk sources and processing plants but excludes from the municipality milk not produced and pasteurized conformably to the standards as high as those enforced by the receiving city."

The recommended milk ordinance has already been adopted voluntarily by many localities. To encourage these communities to attain and maintain a high level of excellence in enforcing the ordinance, the Public Health Service publishes a list of counties and municipalities that under the ordinance have a milk rating of 90 percent for both pasteurized and raw milk marketed within its limits. The list as recently published contains the names of 160 cities and counties in 20 States.

●

"The protection of childhood is costly. The standards we are willing to accept and carry forward are a test of democracy because they are a test of whether it is the popular will to pay the cost of what we agree is essential to the wise and safe bringing up of children."

Julia C. Lathrop, 1919

FOR YOUR BOOKSHELF

JUVENILE COURT STATISTICS 1946–1949. Children's Bureau Statistical Series No. 8. Federal Security Agency, Social Security Administration, Children's Bureau, Washington, 1951. Processed. 16 pp. Single copies free.

About 12 in every 1,000 children in the Nation between the ages of 7 and 17 came to the attention of juvenile courts in 1949 because of delinquency, according to this most recent of the Children's Bureau statistical reports on juvenile delinquency.

The year saw a 4-percent increase in juvenile-court delinquency cases over 1948, and the reversal of a downward trend that started with the end of World War II. During this period, the number of children in the 7-to-17 age group in the general population remained relatively constant.

The study, which includes not only juvenile-delinquency cases, but also cases of dependency and neglect, as well as "special proceedings," is based on reports from 413

courts in 22 States in 1949. Of these, 218 courts in 15 States have reported on such cases regularly since 1946.

Reports of juvenile-court activity have been published by the Bureau since 1927.

The 413 courts reported a total of 70,616 juvenile-delinquency cases disposed of during 1949. Of this number 58 percent were disposed of unofficially, either after conference or after more intensive social investigation and study.

The study shows the median age of children involved in delinquency cases to be about 15½ years for both boys and girls. Almost 75 percent of the children involved were 14 years of age or older. Boys' cases outnumbered girls' cases by about four to one.

However, a larger percentage of boys than of girls were permitted to remain with their parents pending court decisions. Sixty-three percent of the boys' official cases were handled in this manner, as compared with only 43 percent of the girls'. The difference is related to the reasons for which girls are brought to court, such as sexual promiscuity with its dangers of venereal disease, pregnancy, and so forth. Such misconduct is considered serious enough to require detention in order to protect both the community and the girls.

Ever since the juvenile-court movement began, at the opening of this century, efforts have been made to keep children out of jails, where they frequently have been detained along with adult criminals. Many States now have laws to prohibit jail detention of children. However, the Children's Bureau study shows that in 25 percent of the delinquency cases of children who were detained overnight or longer the child was detained in jail. Usually this method was used because of the lack of suitable detention facilities, particularly in some small towns and rural areas.

The report shows that 218 juvenile courts that reported on dependency and neglect cases during the period from 1946 through 1949 showed an 8-percent decrease in such cases during that period. This decrease may reflect both the high level of employment during the postwar years and the elimination or improvement of many war-associated conditions. The return of fathers from the service and the drop in the number of working mothers made for more normal family life.

Of the total children's cases handled by the 413 courts reporting in 1949, approximately 24,000, or about 24 percent, were cases of dependency and neglect. The median age for children dealt with in such cases was 6½ years; 70 percent of the children involved in dependency and neglect proceedings were under 10 years of age.

A reflection of the increased number of children adopted in the last several years is shown in the 13-percent increase in "special proceedings" cases from 1946 to 1949. Adoption proceedings account for a large part of such cases.

Juvenile-court statistics are gathered on a calendar-year basis. Data on 1950 are currently being gathered, although reports have not been received as yet from all agencies. The upward trend begun in 1949 seems to have continued in 1950, these preliminary figures show.

The report includes a statement calling attention to the limitations of the study. Part of this statement is as follows: "Because of their limitations, juvenile-court statistics alone do not provide a reliable index of the extent of delinquency problems or dependency and neglect situations. In regard to the extent of such problems, they may be particularly misleading when used to make comparisons between one community and another."

OCCUPATIONAL CHOICE; an approach to a general theory. By Eli Ginzberg, Sol W. Ginsburg, M.D., Sidney Axelrad, and John L. Herma. Columbia University Press, New York, 1951. 271 pp. $3.75.

Occupational choice is viewed by these authors as a developmental process. The process, they tell us, begins with a "fantasy stage," in childhood. It continues through a long period of tentative choices, lasting from about 11 years of age up to 18 or 19. And it culminates in a later period of crystallization in which the young person is faced with the necessity of deciding on his occupation.

Since each decision that the boy or girl makes during adolescence is related to his experience up to that point, and in turn influences his future, the authors believe that the process of decision-making is basically irreversible. They believe also that the choice itself, in the period of crystallization, has the quality of a compromise, since the young person has to balance realities against his interests and values. Age 17 the authors consider pivotal, as it is the lowest age at which most young people are ready to strike a balance between these usually conflicting factors.

Looking into the question of family background, the book calls attention to the disadvantages of good students whose families are in a lower-income group, noting that these boys and girls are handicapped by lack of stimulation and guidance toward carrying forward their education, as well as by financial problems.

Provocative suggestions are made concerning the part that parents play, or are unable or reluctant to play, in contributing to the occupational choice of a son or daughter. The book raises searching questions for educators in regard to the age at which young people are expected to make curriculum choices that will narrow their range of vocational choice in the future.

Anyone interested in adolescent development or in vocational counseling should find this analysis suggestive.

The investigations upon which the authors' conclusions are based form part of a larger study of the economics of human resources.

Elizabeth S. Johnson

Illustrations:

Cover and pp. 38 and 40, Philip Bonn for Children's Bureau.

Pp. 34, 35, and 36, Esther Bubley for Children's Bureau.

P. 39, Children's Bureau.

THE CHILD

VOL. 16 NO. 3

NOVEMBER 1951

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

The subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions. Single copies, 15 cents.

CALENDAR

Dec. 3–4. National Social Welfare Assembly. Seventh annual meeting. New York, N. Y.

Dec. 4–6. National Conference on Labor Legislation. Eighteenth annual meeting. Washington, D. C.

Dec. 5–8. Third Pan American Congress of Pediatrics. Montevideo, Uruguay.

Dec. 11–19. Fourth International Congress on Mental Health. Mexico City.

Dec. 26–29. American Economic Association. Sixty-fourth annual meeting. Boston, Mass.

Dec. 26–31. American Association for the Advancement of Science. One hundred and eighteenth annual meeting. Philadelphia, Pa.

Dec. 27–28. Society for Research in Child Development. Annual meeting. In conjunction with the American Association for the Advancement of Science. Philadelphia, Pa.

Dec. 27–29. American Speech and Hearing Association. Twenty-seventh annual meeting. In conjunction with the Speech Association of America. Chicago, Ill.

Dec. 27–29. American Statistical Association. One hundred and eleventh annual meeting. Boston, Mass.

Area conferences, National Child Welfare Division, American Legion:

Dec. 6–8, 1951. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Las Vegas, N. Mex.

Jan. 11–12, 1952. Area D— Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Des Moines, Iowa.

Feb. 1–2, 1952. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Charleston, W. Va.

Mar. 6–8, 1952.—Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Little Rock, Ark.

Mar. 14–15, 1952. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Portland, Me.

U. S. GOVERNMENT PRINTING OFFICE: 1951–952603

THE CHILD

DECEMBER
1951

SYMPOSIUM ON CHILD GROWTH AN

Over the past 20 years all groups working with children have been giving increasing attention to their growth and development. In the field of pediatrics this subject has become recognized as the special science on which medical care and health supervision appropriate to the age of the child is based. Professional workers in other fields of child care are also manifesting increasing interest in the processes of growth and development because these processes are so intimately related to the problems of children's nutrition, education, and mental health. All the processes and stages of growth and development, the interrelationships and the differences between them that are met in different children must be understood if health services are to be of greatest benefit to the individual child and if unfavorable circumstances are to be recognized and dealt with. Interest in this movement was greatly stimulated by the 1930 White House Conference on Child Health and Protection, at which the whole subject of growth and development was explored more thoroughly than it had been previously. Several institutions were organized soon after that conference and have been following children as individuals from many points of view ever since. Hence, we know a good deal more about the subject than we did 20 years ago.

Harold C. Stuart, M. D.
Moderator of the Symposium

WHY BE INTERESTED IN CHILD GROWTH AND DEVELOPMENT?

ALFRED H. WASHBURN, M. D.

IN DISCUSSING child growth and development we all too frequently plunge into a presentation of height and weight curves; or we discuss intelligence scores and school achievement, or some other specific and limited aspect of child growth, without giving thought to the total problem. For most of us the goal can be simply stated. It is the better understanding of a given child—or, for that matter, of a given adult—who behaves as he does because of the experiences he has had during his whole span of growth and development.

Let us consider child growth and development not as occurring in a vacuum but progressing dynamically in a given human being, who is continuously reacting, adapting, and adjusting to all sorts of environmental factors, from conception on. We are, then, interested in whatever happens to this individual during growth.

The inevitable relationship between the growth of the child and the nature of the resulting adult represents the first and most obvious reason for the interest of the public-health worker in the topic of this symposium. But this is by no means the entire answer to our question, "Why be interested in growth and development?" At the first meeting of the Society for Research in Child Development, in 1934, its president, Dr. Robert S. Woodworth, gave a beautifully concise answer to our question. He said in part:

"The importance of child development as a field of research cannot be called in question. The physical vigor and mental health of the adult depend on the growth process of childhood and youth, as well as on the genetic constitution, which also in all logic comes within the scope of our society. The social characteristics of the adult population have to be formed in early life. But to think of the child as existing simply for the purpose of becoming an adult would be false teleology from the biological standpoint and bad social evaluation as well. The growing child and the maturing youth are not mere means to an end but are entitled to full recognition in their own right. At any rate the student of child development has his eye fixed on the developmental process itself as something supremely fascinating and worthy of investigation."

The progress of research in human growth since then has served to reemphasize continuously Dr. Woodworth's two main points. The study of growth is fascinating in itself whether one is considering the developing embryo, the baby's first year, or the adolescent boy's dramatic blossoming out into manhood.

EVELOPMENT

This symposium was presented at the seventy-eighth annual meeting of the American Public Health Association, and related organizations, at St. Louis, Mo. The session at which the symposium took place was a joint meeting of three sections of the Association — The Food and Nutrition Section, the Maternal and Child Health Section, and the School Health Section—and the American School Health Association. The material published here is condensed from the papers given at the symposium.

At the same time more and more evidence is accumulating to demonstrate the meaningfulness to the individual of the particular experiences that he has as he grows through infancy and the early childhood years. Thus, we may think of the health or wholeness of the young adult, his soundness as a good citizen of the world, as being dependent upon the success that he had during childhood in adapting his self, his own unique individuality, to his world. And further, we may think of the baby or child at any age being an individual already uniquely himself and deserving of our sympathetic understanding.

Individuals vary within the pattern

In this problem of understanding the growth and development of an individual person, whether he be infant, child, or adult, there are two quite simple concepts that need to be a continuous part of one's thinking. The first is that every healthy child's development progresses according to and within the limits of the general human pattern.

Even though this is obvious, yet it rema[illegible]ue that one of our important tasks in studying human growth is the clearer delineation of the human pattern. To be sure, we have a fairly reliable picture of the pattern of weight and height increase, as well as that of the changes in a good many other structures. We have also a somewhat less adequate picture of the pattern by which certain functions develop. But concerning the developmental patterns of many functions, both physiological and psychological, we are still relatively ignorant.

The second concept is concerned with the amount of variation between individuals within the uniformity of the general human pattern. Each individual is unique. Let me use a very homely illustration to bring out the fact of how completely we all accept this idea even though we may not always act in accord with it when dealing with children.

We will assume that you are to meet a friend at the railroad station. Even though there may be several hundred persons going and coming through the station you will have no difficulty knowing which one is your friend as soon as you see him. In fact, even though he may approach you from behind, when he speaks your name you will know who he is before you see him.

We do not always give sufficient thought to the fact that his internal structures, such as heart or lungs, are just as characteristically and uniquely his as are his eyes and nose or body build. So too his less obvious physiological and psychological functions are just as characteristic for him as are his walk, his voice, or the cheeriness of his greeting. Within the limits of the general human pattern there are almost endless individual variations.

I should like to carry these thoughts about differences between individuals a step further. It is not just a question of any two of us being of different stature, or having differently shaped noses, or presenting different degrees of efficiency in the functioning of our heart and circulatory or central nervous systems. As I have suggested above, each of us represents the end product — in both structure and functioning — of a long and continuous series of interactions that have taken place during growth and adaptation. Often striking individual variations are to be found in the pathways that we have traveled in reaching our present end point. Or, put in a slightly different way, the patterns revealed by charting out the growth of a given structure or the development of a given function may vary greatly from child to child.

Babies gain at different rates

A nice illustration of this in the realm of structural change may be seen in the weight curves of two selected babies during their first 12 months of life. Even though they start at the same birth weight and weigh the same at 12 months, yet the curves may be quite strikingly dissimilar. For example, the first may rise very steeply in the first 1 to 4 months and then, bending sharply, show very little gain in the last 3 to 4 months. In contrast to this the second may form a more symmetrical arc, with a less steep rise at first and a more rapid rise in the second half of the year. The difference in the timing of adolescence in different children is, of course, a classic and dramatic example of variation in the patterns by which growth progresses in different but equally healthy children.

I shall assume, without further elaboration, that we all accept the existence of endless variation within

Dr. Alfred H. Washburn is Director of the Child Research Council of Denver. He holds the rank of Research Professor of Pediatrics in the University of Colorado School of Medicine, serving also as Chief of the University's Department for the Study of Human Growth.

the limits of the human pattern of growth. I shall assume also that we accept the fact that the individual's own characteristic pattern can be described, studied, and ultimately understood only against the background of the whole range of the human pattern. That is, a given person is tall or has a high blood pressure only relative to all other persons. And if he is 8 feet tall or has a systolic blood pressure of 200 millimeters of mercury then he is outside of the range of the healthy human pattern. But even assuming acceptance of these basic concepts one may still ask what is their significance for those of us who are dealing with the health and welfare of growing children.

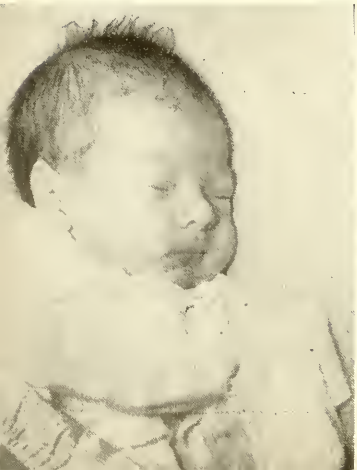
We need to know about the individual

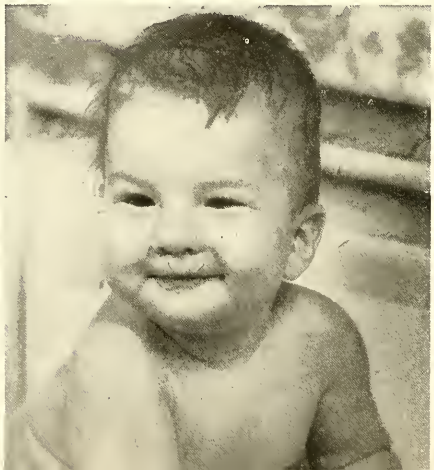
During the last quarter of a century we have learned much about individual variations during growth. We have come to realize that these are meaningful for the individual—that the safeguarding of health involves some insight into the individual's unique pattern of growth—that the adequate diagnosing and treating of disease in a child necessitates knowing something of the nature of that child as well as of the peculiarities of the disease from which he happens to be suffering. For example, the difference in heart size between the smallest and largest hearts, which we have observed in healthy 8- to 10-year-old boys, is greater than the amount of increase one would usually see resulting from mild to moderately severe involvement with rheumatic fever. Or again, in boys undergoing a rapid adolescent growth spurt in both height and weight, the degree and rapidity of increase in heart size may closely approximate that seen in a preadolescent boy with progressive enlargement due to active rheumatic carditis. It is obvious that the possibility of correctly diagnosing pathologic enlargement of the heart implies an appreciation of these variations and growth patterns.

Although this is a fair illustration of the importance of studying human growth, yet it tells only part of the story. Public health is concerned with prevention as well as with the diagnosis and cure of disease. Prevention implies being able to look ahead—being able to predict with some measure of reliability. For example, preventing caries and defects in deciduous teeth necessitates a knowledge of the timing of the development of these teeth. And this, in turn, leads to concern with the adequacy of the mother's prenatal diet as well as with that of the baby after birth. Parenthetically one might add that our knowledge of such food requirements is still far from complete. Prevention of a number of so-called congenital anomalies of the heart, eyes, palate, or limbs of the expected baby similarly implies a knowledge of their pattern and varying speed of development at different stages. With this knowledge we can make every effort to protect the mother from infectious diseases and dietary deficiencies, particularly during the time of the baby's development in the uterus when they are most apt to distort the orderly progress of that part. We may accept, therefore, the thesis that the adequate diagnosis and prevention of disease is greatly dependent upon an understanding of human growth; but let us go a step further.

What leads us to study child development?

Most of us in such a group as this have accepted our responsibility for attempting more than the prevention of disease. To be sure, we must continue actively in this never-ending campaign against the diseases that plague mankind, but we must also learn how to educate people positively for health and happiness. We recognize that there is a difference between the mere absence of disease and the presence of robust good health. We feel sure that robust good health and stable adaptation to our environment make us more valuable as well as more delightful citizens of a democracy. But, alas, we are not nearly so sure just how one becomes and remains a healthy and happy citizen. The desire for this knowledge serves as a powerful stimulus for studies of the growth and development of individual children, such as those in which some of us are now engaged. I wish it were possible to give a complete record of the growth and development of just one subject followed in the Child Research Council for 10 or 15 years, but it takes





the staff a whole morning to review one such record. Instead, I shall just suggest the kinds of questions raised by such studies.

Jane is now a young woman of 18 years. She was a relatively small baby, born of parents whose size was somewhat below the average for the population. Throughout her childhood her height remained in the lowest 10 percent of our group of healthy girls. Her weight was always well below the tenth percentile, and tended to lag behind the tenth percentile curve in its rate of increase. Her thinness and slow growth were a source of worry to her parents, to teachers, to visiting nurses, and to physicians.

And yet her health record shows that she had fewer illnesses than the average and that her recovery from illness was usually prompter than that of the average child. Moreover, her intellectual development and her degree of emotional maturity were well ahead of the average. She usually seemed to be a pleasant, happy, and active child. Today she is a charming, popular, and bright young college woman, healthy and well-adjusted to her environment.

Long-time studies help

What factors in her constitutional make-up or in her early development should have served to tell us that she was progressing satisfactorily toward a healthy, happy young adult life? How can we distinguish between the naturally small, slowly growing child and the one who is small or slow to develop because of dietary deficiency, chronic illness, emotional handicaps, or a combination of such causal factors? Answers to such questions can come only from long-time studies of individual human beings.

We need to study each child as a whole integrated organism. Changing structure and function in a given child are really inseparable. Thus we must study structure — its changes during growth, its use to the individual, and its variations in different children — in such a manner as to lead to maximum opportunity to relate the structure studied to the total behavior, to the individuality of the person.

Many factors are involved

For instance, the pattern of a given child's changing bone structure at adolescence is closely related to the change in the basal metabolic rate; to increased food intake; to the appearance of secondary sex characteristics; in girls, to the onset of the menses; and to various other physiological and psychological changes.

However, both the chronological age at which these events occur and the precise pattern, involving speed of progress and duration of these changes, will vary greatly in different children. Each child during health follows his own pathway at his own speed. Thus the safe interpretation of such findings as "bone age" or "basal metabolism" must depend upon some familiarity with the particular individual and his own characteristic mode of progress. I do not mean to imply that this is a simple matter, as my next illustration will show.

What of his home life?

Jim is a slender boy of 14 years, not yet adolescent. In infancy and early childhood it seemed as though he was almost never completely well. He was allergic to many substances, he had innumerable minor colds, and many attacks of more severe respiratory tract infections. His recovery from illness was often slow and far from satisfactory. His eating habits, particularly in the preschool years, were erratic, leading to uncertain food intake even though his parents and his doctor supposedly did their best to give him an adequate diet.

But there were other important factors at work throughout his infancy and early childhood. His mother, who appeared, superficially, to be doing everything possible for him, was actually hostile to him from early infancy. A careful and thoughtful study of his regime—partly in retrospect—led us to the conclusion that she was often severely punitive in carrying out treatment for his endless symptoms. Sometimes as many as 10 to 12 medications had been used in one illness of a week or 10 days. Not only was he overtreated in nearly every sickness, but he even had several quite unnecessary operations, urged by the mother and carried out by an obliging doctor with too little awareness of the possible

mother-child relationship.

At 14 years he is in somewhat better health, though far from robust, and overconscious of potential disease. He is a far from happy boy, poorly adjusted in his neighborhood and school.

One may well ask how much of his early illness was precipitated by his mother's hostility and his resulting lack of love or security. Could his present status have been foreseen by the time he was 4 or 5 years old? If so, what could have been done then? Was he already seriously injured, physically, physiologically, and psychologically before he reached school age? How early in the life span must we be applying that form of preventive medicine which seeks to foster and encourage a positive program for health? And, finally, how shall we teach doctors and nurses and nutritionists to be aware of these problems so that they may avoid the error that Jim's doctor made of assuming that the mother was simply overconscientious — an error that led to his being used as the mother's accomplice in punishing Jim?

The importance of the effect of the personality characteristics of both parents and child on the total functioning of the individual infant or child, in health as well as in disease, is now generally accepted. Although investigation into the development of these traits in the early years is difficult, yet we know that the first 5 to 6 years represent a most important period for study if we are to understand adequately the behavior of the school child, the adolescent, or the young adult. Thoughtful observation of the interplay between the baby and his environment, starting with the mother, may give valuable clues concerning the individual's basic traits, and their development or modification, as he attempts to adapt to his environment. In a play setting, whether it be dolls, or clay, or paints, or just free play, the preschool-age child often reveals much of himself—his fears, his loves, his anxieties, his aspirations, the concepts of his little world, and just as in the more purely physical aspects of growth, so here, too, we need less emphasis on the mere measurement of status at a given moment and more emphasis on what the child is becoming, as well as on the "how" and the "why" of the becoming. Furthermore, we need more awareness of and more concentration on the interrelatedness of changes in structure, in physiological functioning, and in the development of emotional and other aspects of personality.

As we continue our studies in the Child Research Council, we are following the same individuals through childhood into their adult lives. We have now a score of young adults and five second-generation babies. Year by year the kind of evidence I have been discussing becomes more convincing. Individual variations have meaning. The pattern by which each child progresses is unique; but it is orderly for that child, if growth is healthy. The child's own pattern holds meaning not only concerning what sort of child he is now, but also in regard to what sort of older child or adult he is in the process of becoming. There is, of course, equally convincing evidence that environmental influences—the nature of the setting within which growth is occurring—may alter the pattern to a greater or lesser extent in different children. More studies on more persons, carried on through more than one generation, are urgently needed in order to provide adequate knowledge in this field. The usefulness of such knowledge to public-health workers in the future cannot be questioned. In fact, an adequate program for promulgating positive health measures is dependent upon a better understanding of human growth and adaptation.

Reprints in about 6 weeks

A RESEARCH INSTITUTE ON CHILD GROWTH AND DEVELOPMENT REPORTS PROGRESS

LESTER W. SONTAG, M. D.

THE Fels Research Institute was set up to study "prenatal and postnatal environment." Heredity, although not mentioned, was, of course, to be dealt with. The Institute was organized with the idea that we would measure as many behavioral, physiological, growth, and environmental factors as we could, over as long a time as we could. The program was, therefore, to involve many fields of study — to be "interdisciplinary." We envisioned as the research product a better delineation of normal values for many characteristics, and a better understanding of the meaning of individual deviations. We also banked heavily, if somewhat naively, on being able to demonstrate, and then understand, the relationship between various physiological, growth, maturational, and behavioral characteristics. Our basic objectives have not changed over the years, but I hope that our scientific sophistication has. Certainly our approach to the problems and our methods of attack have been greatly modified.

Here are some of the things we have learned and the conclusions we have come to about the organi-

zation of our project, our mode of procedure, and the way we hope to accomplish our purposes.

1. We found that the empirical selection of the characteristics we intended to measure — the mere measurement of as many individual characteristics of children as possible — and continuing the measurements over a long period, failed to yield us very satisfying scientific returns.

2. Increasingly we found it necessary to plan the specific use of data before they were collected. Unless such planning was done, the data more often than not proved inadequate for any attempt to solve problems later posed.

3. We found that in the field of child development, as in most other fields of science, the formulation of hypotheses is an important factor in sharpening research planning and stimulating research effort.

4. Our staff has all come to realize increasingly that the emotional needs of workers devoted to long-term projects such as child-development research are of extreme importance in planning a program. Relatively few individuals with initiative and creative minds find it easy to work toward the long-term goals of longitudinal studies of child development without having the program so designed as to create for each of them a series of sub-end points. Such an organization of program permits each staff member to undertake a series of publications in a given field or area which enables him to build for himself a position of authority and reputation in that area. The advantages to the scientific fraternity of the publication of such research results as they are achieved seems obvious.

5. We find that it is profitable to consider longitudinal research not only in terms of the lifetime of an individual but also as a series of periods of his lifetime. In other words, for many problems, the individual's life may be best considered in terms of a series of periods, for example, from 2 to 10 years.

6. We have been increasingly impressed with the fact that although simultaneous descriptions of a child in various disciplinary categories is interesting and challenging, it is not in itself productive of research results that we can adequately communicate to others. Our work has therefore increasingly tended to become a synthesis of factors designed to enable us to understand various aspects of the individual, working from the simple to the complex.

7. As the quality of staff has risen from year to year, staff members require greater autonomy in expressing their research interests, with the result that the cohesiveness and interrelationship of the objectives of the program has decreased.

8. The occasional use of a group of abnormal individuals for the purpose of formulating hypotheses and understanding normal processes is desirable. Examples of the type of study in which this is done are the study of steroids in the urine of children with precocious sexual development and the study of physiological responses to stress in cases of acute anxiety neuroses.

The work of the Institute is divided into four departments: Physical growth, biochemistry, psychophysiology, and psychology.

Physical growth

At first the work in physical growth emphasized primarily skeletal growth, patterns of appearance of ossification centers, and factors influencing such patterns. In recent years, however, emphasis has been placed increasingly on differential distribution of soft tissue throughout the body, as measured by a series of X-ray sections. Points of inquiry for the soft-tissue study are growth differentials and sex differences. The over-all objective of this work is to develop a method of describing body type in terms of differentials of soft-tissue distribution. The evolution of such a method, which is well along in its progress, will greatly stimulate an interdisciplinary aspect of our program, since it will then be possible to investigate possible relationships between body type, physiological responses to stress, certain aspects of social adaptation, and perhaps biochemical or physiological function.

Biochemistry

Our biochemistry department is in a much earlier developmental stage than is our department of physical growth. This is not only because the biochemistry department has been established more recently, but also because there is less clarity of precedent as to what biochemical characteristics of the child offer greatest promise of explaining important aspects of his structure or function. As a result our biochemistry department is in an active exploratory phase. At the moment it has elected to study both gonadal and cortical steroids. It may spend 2 or 3 years in modification of techniques for fractionation of steroids. It will at the same time be producing normative curves of steroid excretion in boys and girls. It has investigated the consistency of day-by-day steroid excretion, so that if at a later date it wishes to attempt to relate steroid excretion to rate of maturation or growth or to autonomic response pattern, it will know the sampling validity of its data. The biochemistry department is also investigating the role of alkaline phosphatase in the blood of growing children, and the significance of individual differences in its blood level. It is just finishing a study of vitamin levels in the blood of children and the relationship of such levels to intake, as measured qualitatively. It is working with the blood enzyme glucuronidase.

Psychophysiology

Our psychophysiology work is of fairly recent origin. The over-all plan of this department is to measure individual stress responses of skin conductance, skin temperature,

blood pressure, heart rate, and blood flow. We should like to know how such responses differ; whether they are gene-determined; to what degree they change with day-by-day emotional stress; what maturational changes occur. We want to know their relationship to later psychosomatic disturbances, and whether they are predictive of such disturbances; in what way they are related to personality structure; and whether they have biochemical, growth, or structural correlates. By this time, these psychophysiological measures are rapidly becoming a useful tool. Actually at the present time they are being used in an interdisciplinary problem, along with the Rorschach test, in attempting to determine the relationship of autonomic instability to anxiety in children.

Psychology

Although our psychology department is still concerned with a variety of aspects of behavior, its work is focused primarily on two major areas. They are: Resolution of infantile dependent needs of children into adult ego needs; and the ways in which different constellations of environment, primarily parental environment, modify and distort that resolution. The areas of study are, therefore, the constellation of parent behavior and the methods developed by individuals for the gratification of residual dependent need, together with defenses against the anxiety caused by frustration of such need. Publications to date have been primarily on the subject of measurement of parent behavior and the descriptions of different constellations of such behavior.

In the field of fetal behavior, an area of investigation in which the institute contributed considerably in its early years, we have of late been relatively inactive.

I have been somewhat hesitant in reporting, in a symposium on child growth and development, the activities of a single institute. Since, however, the experiences of other investigators in developing a research philosophy and a mode of operation for research in child development are probably comparable, I have been perhaps giving a general idea of the work of similar organizations in this field.

Dr. Lester Warren Sontag is Director of the Fels Research Institute for the Study of Human Development, and he is a Fellow in Psychiatry at the University of Cincinnati Medical School Department of Psychiatry. Dr. Sontag initiated the program of the Fels Research Institute 22 years ago and has continued as its director through the period of its growth into the largest institution of its kind in the world. Dr. Sontag is President of the Society for Research in Child Development.

Reprints in about 6 weeks

UNFAVORABLE LIVING CONDITIONS MAY HOLD BACK CHILDREN'S GROWTH

A pediatrician needs to question the background of an undersized child

JULIAN D. BOYD, M. D.

MOST PEOPLE take a child's physique for granted. They believe that since size and body build are largely controlled by inheritance, little or nothing can be done after birth to change an individual's physique. The general public, and even many professional workers, accept the fact that there are small children and large children at any given age; and they may have no more concern for littleness or bigness except as it relates to a child's clothing, or the height of his desk, or other such practical matters. Oftentimes school authorities have been discouraged from having physical measurements made of children because the parents consider these measurements useless. If it is assumed that physique is inborn, why should anyone be greatly concerned about it?

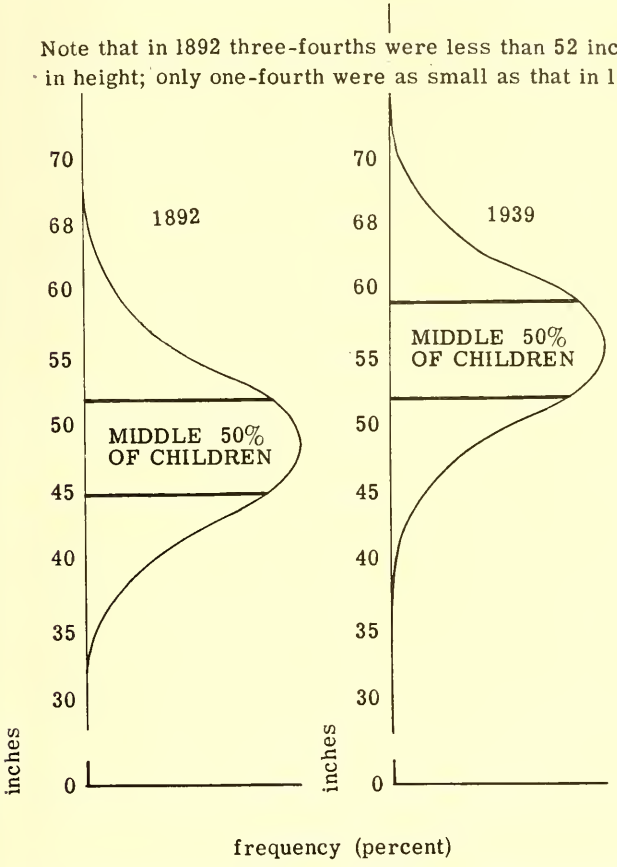
For years, anthropometric studies have pointed to the fact that though growth in height and weight indeed depends upon genetic factors, it is also subject to modification by conditions of living. As a pediatrician interested in child growth from the point of view of promoting child health, I feel that the findings of these studies should be applied more

widely in appraising the health of children.

To supplement his own studies of child growth, which I shall refer to later, Dr. Howard V. Meredith has reviewed and correlated many sets of measurements that have been published by other students of anthropometry during the past two or three generations. He has examined the measurements of a number of comparable groups of children—measurements made decades apart; and he finds that with the passage of time the average stature and weight of groups of children of similar ancestry and economic status have increased significantly, and that the increase is not limited to one race, or one economic level, or one age period of childhood. [2, 3, 4, 5]

One of these comparisons is shown in the chart on this page, in which the average height of 832 10-year-old girls measured in Toronto, Canada, in 1892, is compared with that of a group of 4,468 10-year-old girls measured in the same city in 1939. [6] As the chart shows, the girls measured in 1939 were in general taller than those measured more than four decades earlier. The heights of the middle 50 percent of the girls measured in 1892 ranged from 45 to 52 inches. Among those measured four decades later, the height of the middle 50 percent ranged from 52 to 59 inches.

DIFFERENCES IN STATURE, 1892 AND 1938;
10-YEAR-OLD GIRLS IN TORONTO, CANADA



Based on figures collected by Meredith [6]. The 1892 figures are from Franz Boas: Growth of Toronto Children. In Report of Commissioner of Education, 1896–97, vol. 2, pp. 1541–1599. Washington. The 1939 figures are from A Height and Weight Survey of Toronto Elementary School Children 1939. Department of Trade and Commerce, Dominion Bureau of Statistics. Ottawa, 1942. 36 pp.

Another comparison appears in the table on page 58, which shows 6 to 9 percent greater height and 8 to 15 percent greater weight for 9-year-old boys measured in fairly recent years than for boys of the same age measured in the nineteenth century. The increased height and weight occurred in three groups of boys, all born in the United States: a group who were of North European ancestry and high economic status; another group, of Italian ancestry and low economic status; and a third, of Negro ancestry, who were unselected as to economic status. In some of these studies the number of children was rather small; nevertheless the differences that occurred with the passage of time were consistent with those found in the Toronto comparison and in a number of others reported in the literature.

These and other examples of the increases in height and weight noted by Meredith have taken place during a period that has been characterized by progressive lowering of the infant mortality rate, by lengthening of life expectancy, by decline in the incidence of many infectious diseases almost to the vanishing point, and by development and application of the modern science of nutrition.

Meredith's observations support the view that modern living conditions tend to promote growth in greater measure than did conditions prevalent two and three generations ago. His observations agree with

those of many other workers, whose studies indicate that both in this country and in diverse regions abroad, young adults nowadays are taller than were those of the past. This difference, he believes, points directly to the conclusion that more healthful living conditions are associated with greater size, within the limits of each child's heritage.

AVERAGE HEIGHTS AND WEIGHTS OF VARIOUS GROUPS OF 9-YEAR-OLD BOYS BORN IN THE UNITED STATES

From Meredith [3]

I Boys of North European ancestry and of high economic status

Year	Height (inches)	Weight (pounds)	Investigator
1938	53.5	69.5	Simmons and Todd [1]
1879	50.4	61.1	Bowditch [2]
Difference	3.1 (6.1%)	8.4 (13.7%)	

II Boys of Italian ancestry and of low economic status

Year	Height (inches)	Weight (pounds)	Investigator
1939	50.8	59.5	Matheny and Meredith [3]
1899	46.8	51.8	Hrdlicka [4]
Difference	4.0 (8.5%)	7.7 (14.8%)	

III Boys of Negro ancestry and of unselected economic status

Year	Height (inches)	Weight (pounds)	Investigator
1941	52.2	63.9	Lloyd-Jones [5]
1898	49.3	59.0	MacDonald [6]
Difference	2.9 (5.8%)	4.9 (8.3%)	

[1] Simmons, K., and Todd, T. W.: Growth of Well Children; analysis of stature and weight, 3 months to 13 years. Growth, vol. 2, pp. 93-134. 1938.
[2] Bowditch, H. P.: The Growth of Children; a supplementary investigation. In Tenth Annual Report of the State Board of Health of Massachusetts. 1879. pp. 35-62.
[3] Unpublished.
[4] Hrdlicka, A.: Anthropological Investigations on One Thousand White and Colored Children of Both Sexes, the Inmates of the New York Juvenile Asylum; with additional notes on 100 colored children of the New York Colored Orphan Asylum. Wynecoop, Hallenbeck, Crawford Co. New York, 1900.
[5] Lloyd-Jones, Orren: Race and Stature; a study of Los Angeles school children. Research Quarterly, vol. 12: 83-97. March 1941.
[6] MacDonald, Arthur: Experimental Study of Children, Including Anthropometrical and Psychosocial Measurements of Washington School Children. In Report of Commissioner of Education, 1897-98, vol. 1, pp. 985-1204. U. S. Department of the Interior, Bureau of Education, Washington.

Meredith's studies began a number of years ago, when, as part of the child-study program of the Iowa Child Welfare Research Station, he and his associates began a series of measurements of large numbers of Iowa City children — weighing and measuring each child at regular intervals from early infancy through adolescence. The children were chiefly from families of middle economic status, many of them from university circles.

The measurements obtained on these Iowa City children from birth to 6 years correspond almost exactly with measurements reported by Vickers and Stuart for children in Boston. [9] And for older children no great differences appear between the Iowa City and the Boston data. We must remember that in both places the children measured were for the most part from families in the middle-income range, and that among these families the requisites for comfortable living and for health protection are likely to be more readily available than among families in general.

Even among a presumably favored group of children, whose average size is larger than that of children in lower economic groups, we find various rates of gain and a wide range in heights and weights. How are we to explain such great differences among children of a relatively homogeneous group? Are we justified in assuming that the variations are accounted for by heredity alone? Probably not, for we know that even in high economic groups the living habits of families vary. Therefore it behooves the pediatrician who encounters a child who seems undersized or underweight to consider carefully whether that child's growth may have been retarded by unhealthful living practices.

An example of varying gains in stature at different ages is given in the chart on page 59. The chart on page 61 shows growth curves that illustrate that the growth of children of similar ancestry who are of the same height in early childhood may differ rather widely later.

Well-known examples of factors that interfere with a child's optimum growth are those that impair his nutrition — conditions that lead to insufficient intake of the needed foods or to poor digestion, assimilation, or utilization of what he eats. Of these factors, inadequate intake of the needed foods would be the one most suspect in a child whose measurements are below the average for his group, especially if he is otherwise normal and in apparent health.

How are we to pick out the child whose growth is retarded by factors in his living conditions? Surely this question is important to every worker in the field of health.

To estimate desirable growth levels

One step toward finding the answer to this question is to use a suitable standard for growth. In our clinical work in the pediatric department of the State University of Iowa we found that the usual standards of height and weight for age were too low for the children we observed, even for those who were ill. In these standards the range for any given age was so broad that it included the measure-

Dr. Julian D. Boyd is Professor of Pediatrics at the State University of Iowa. His publications have dealt with the management of diabetes mellitus in children, the prevention of tooth decay, and the promotion of health through dietary practices.

ments of almost any child of that age we might encounter. It seemed to us that we needed standards based on measurements of children living under favorable circumstances—that such standards would permit a better estimate of desirable growth levels than did those standards that were based on measurements of a diverse child population.

Looking for more representative standards by which to judge our local children, we turned to Meredith's Iowa City data, and planned charts to be used in comparing the measurements of an individual child with the standard for children of his age in this group. Separate charts were made for boys and for girls, each chart to cover one of three age periods: Birth to 1 year, birth to 6 years, and 5 to 18 years. All the charts were planned for recording height and weight; the charts for the period from birth to 1 year were planned also for recording head measurements.

For each age group of boys and of girls, I mapped out the central range, or zone of values, where measurements of two-thirds of the children in Meredith's series were found. One of these charts is reproduced on page 60. Similar charts have been constructed by Stuart and Meredith [8] and by Meredith [7], the latter including additional body measurements.

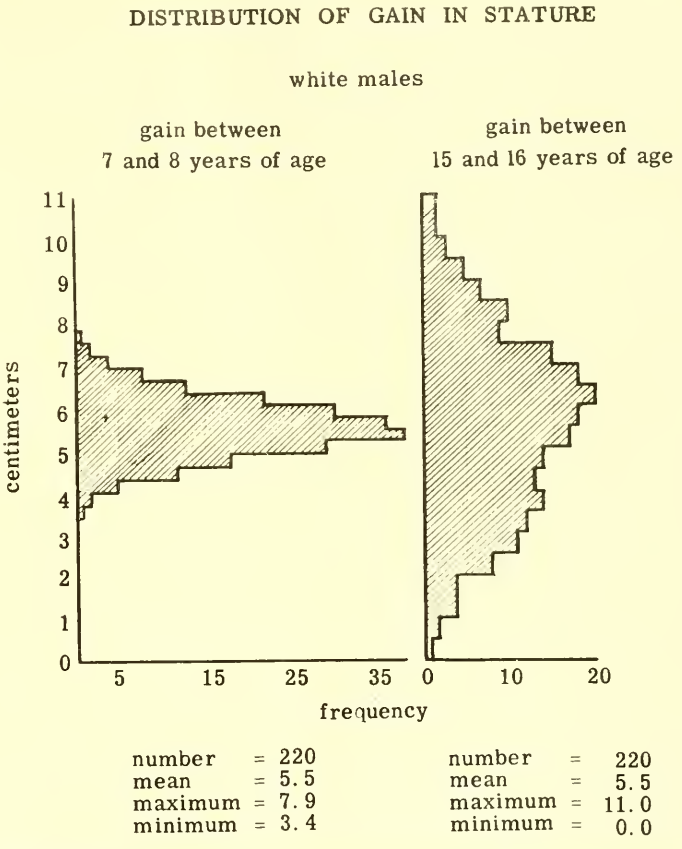
Each of these forms of chart has proved useful in comparing repeated measurements of an individual child with well-defined standards. The set of charts first described has been used routinely in our pediatric clinics for several years, both for well infants and children and for those with diseases.

The first step in our examination is for a staff member to take the child's measurements and to plot these measurements on the chart in terms of his chronologic age. Then, before taking the child's medical history, the physician compares the measurements with the corresponding standard measurements. He then directs his questions and his techniques of examination toward determining the significance and possible causes of any deviations.

He assumes that noteworthy deviations from the standard stem largely from environmental factors rather than from genetic ones; and he holds this assumption until careful questioning and examination procedures show that unfavorable environmental factors have not been operating. If adverse factors have been operating at an earlier time, he assumes that they are still operating, unless he finds that some marked break with previous patterns of living has taken place.

Since substandard dietary habits are so common among children, it is the rule rather than the exception for the physician who is examining an undersized or underweight child to hear a story of poor eating practices. [1] At that stage of the interview, the mother of such a child, having been brought skillfully to recognize that her child's eating practices have not been up to a desirable standard, usually is receptive to advice that will help her to improve not only her child's nutrition but other aspects of his health. Repeatedly, after such an interview, we have seen a child's later growth curve swing abruptly toward normal. Oftentimes disturbances in the child's health or behavior likewise have disappeared.

In summary: Growth is determined through the interplay of two



This chart, from Meredith [2], shows gain in stature of 220 boys between 7 and 8 years of age and of the same boys when between 15 and 16 years of age.

sets of forces — genetic factors and living habits. A child's genetic propensities determine his maximum capacity for development. The degree to which he is able to achieve the pattern set for him by his heredity will reflect the balance between favorable and unfavorable conditions in his environment from the time of conception through his whole period of growth.

Various factors can slow down growth

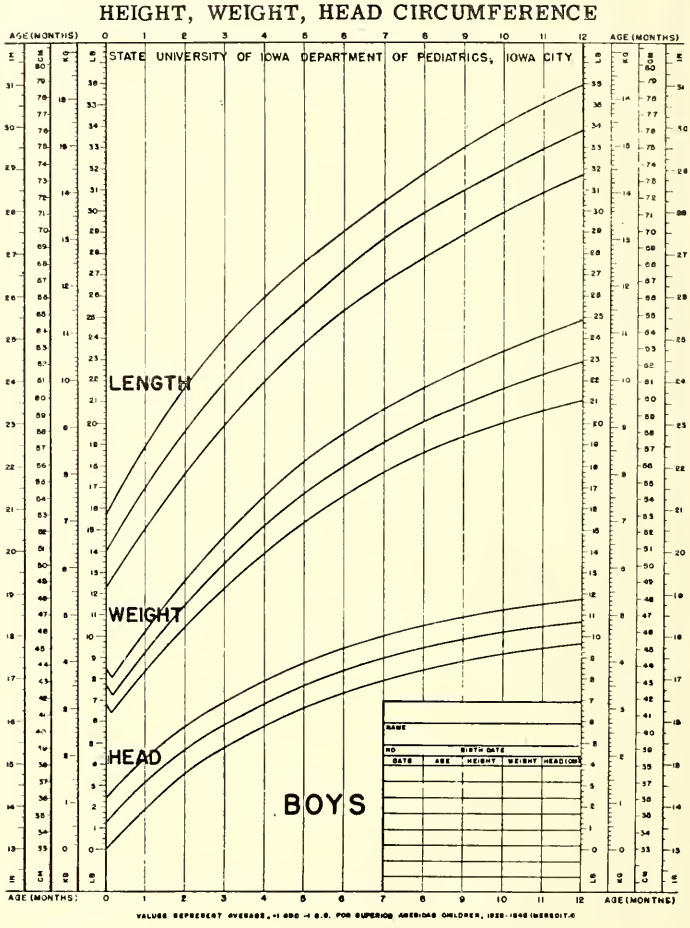
Recognizing that genetics plays a determining role in establishing the upper limits of growth and development, it is important for all of us to recognize also that faulty environmental circumstances often slow down a child's native growth rate and interfere with the full development of his physique, even though these circumstances may not make themselves apparent through other signs.

Unfavorable factors need not be spectacular to be effective; on the contrary, various common and apparently innocuous errors of environment can slow a child's rate of growth and can cause him to remain unnecessarily small when he reaches adulthood. Many years of clinical observations have led me to conclude that such slowing of growth is common among children, and that it frequently reflects poor diet practices. Therefore workers in the field of health should be trained properly to interpret growth standards and standards of nutrition.

It is well known that many accessory factors may lead to faulty nutrition; these include chronic physical or emotional fatigue, recurrent infections, emotional disturbances, and sometimes metabolic derangements. Persistent demands on a child that exceed his capacities, physical, mental, or emotional, may affect his growth unfavorably.

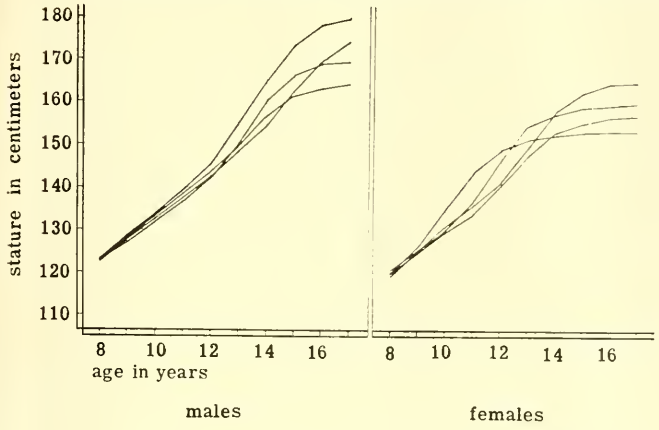
If a child is not small by inheritance, conditions that cause him to be undersized and underweight often are the forerunners of more obvious and more severe disturbances of his health.

Interest in causes of deviations from normal height and weight in a child, presented here from the standpoint of a pediatrician, is shared by the school doctor and nurse, the social worker, and every other professional worker who is concerned with the entire child. Each of us should work toward fulfilling the child's best possibilities and toward controlling factors that may lead to adverse conditions. Recognizing this common interest, I believe that continuing appraisal of physical growth should be a part of the regular examinations of the infant and the older child, whether or not disease is suspected. If a child's body length or weight is much below par according to a well-defined and appropriate standard, his pattern of living should be meticulously investigated to determine whether some fault in that pattern is responsible for the lag in the child's physical development.



This is one of the six charts—8½" by 11"—devised by the author for recording repeated measurements of children. For specimen copies write to Department of Pediatrics. State University of Iowa, Iowa City. The charts may be had in quantity, at $1 per pad of 100, from the Publications Department of the University.

INDIVIDUAL CURVES FOR FOUR BOYS AND FOUR GIRLS WHO WERE APPROXIMATELY IDENTICAL IN STATURE AT 8 YEARS OF AGE AND WIDELY DIVERGENT AT 17 YEARS



Growth curves from 8 to 17 years are given here for four boys and four girls, who were approximately of the same height at 8 years, but were widely divergent at 17. The chart is from Meredith [2], based on data from the Harvard Growth Study.

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Reprints in about 6 weeks

HOW CAN WE APPLY OUR KNOWLEDGE OF CHILD GROWTH AND DEVELOPMENT?

HAROLD C. STUART, M. D.

DR WASHBURN makes it clear that if a study of a child's growth and development is to be adequately broad, it must include consideration of his parents, his family, and his community, to provide background and understanding of the individual characteristics of his progress. Especially such studies must consider the mother's health during that important period of development extending from the baby's conception to his birth.

The studies that have been in progress at the Harvard School of Public Health during the past 20 years have devoted particular attention to the diet and nutritional state of the mother and the relation between these and the occurrences of pregnancy and the development of the fetus. Dr. Washburn and Dr. Sontag have been actively interested in maternal health problems from this point of view. It is clear that the need for knowledge of family background, and of the mother's health, and of family welfare in the community applies equally to child-health services, which confront the problems of growth and development in relation to health and individual fitness.

A feature of Dr. Washburn's paper is the emphasis he places on gaining an understanding of why a particular child grows and develops as he does, and not merely on how children in general grow, nor even on how this child grows. The marriage between the science of human ontogeny — the development of the child from conception to maturity— and the science of human ecology— the interrelationships between the individual and his environment, and the adaptations between them — is as essential to child-health services as to research. Public health essentially is concerned with the environment and with the adaptations of human beings to it, the points at which these adaptations frequently break down, and the control of the environmental factors that commonly cause such failures. The environment must be more strictly controlled for the child than for the adult. But the child's environment is continually changing—and should

be permitted to change — as his abilities to make successful adaptations improve through the natural processes of growth and development.

In Dr. Sontag's remarks he makes it clear that many difficulties must be overcome if one is to carry out the kinds of studies of the growth and development of children that we are considering. All sorts of problems are introduced by the duration of such projects: Maintaining continuing contacts with the children being studied; the inevitable changes in staff; the growth and consequent change in point of view of individual workers; the necessary alterations in plans consequent upon depressions and wars.

Dr. Sontag does not suggest that the whole story is nutrition or emotion or something else, but rather that all fields must be carefully considered, evaluated individually, and related one to the other. We expect each representative of a specific field to be particularly interested in his own subject; but for a group of specialists to work together effectively in the field of child development there must be great understanding on the part of all and capacity for leadership on the part of the director.

In Dr. Boyd's paper he brings out a number of problems that we all recognize as involved when one is trying to evaluate the growth and development of an individual child and to understand the significance of unusual findings. He has made it clear that it is difficult, if not impossible, on the basis of a single examination, to make any definite statements about the significance of the findings, whether they be that the child is small or large for his age; that his growth has been slow or rapid, or other special features. Without knowing the child's background, one can only hazard a guess as to the suitability or even normality of the findings. He brought out the fact, however, that by continuing to examine the child periodically, one can gradually develop a picture of the appropriate pattern of growth for that child.

I think Dr. Boyd will agree that when we find a deviation from expected progress and obtain a history of possibly significant events, we still are not able to say with any assurance that this deviation is due to a specific cause. No matter how thoroughly we have investigated a situation, we are usually uncertain whether the conditions found actually caused the deviation; and, if it is probable that they did, what is the relative importance of each condition.

In order to apply these principles to health services, therefore, we must be aware not only of deviations from expected progress when they occur, but also of the factors in the environment, past and present, that may have accounted for them. It then follows logically that we shall try to correct all the unfavorable conditions that we recognize. But we must have more than sketchy information about a child before we undertake to alter his situation, and we must have some way to change undesirable conditions or habits when they are discovered.

Studies are needed to show, among large groups of children, the frequency of specific kinds of unfavorable conditions, whether defects in care or environment, diseases, nutritional deficiencies, or emotional disturbances, and to obtain a clearer understanding of the frequency of their association with different deviations from normal progress. This kind of information would be useful in finding out and interpreting the probable cause of a marked deviation in a given case. It would be of great help if public-health agencies providing services to children were in a favorable position to collect such data, so as to contribute to the welfare of the children concerned and to add to the general pool of knowledge.

Several questions have been raised regarding longitudinal and comprehensive studies of children and their application in public-health practice. One question has to do with the use of body measurements in following the physical growth of children. It has been pointed out that few measurements, possibly only of height and weight, are needed to bring to the attention of the observer unusual features of a child's build or of his progress. These measurements may be readily obtained by anyone who has enough interest to want them, who takes the trouble to learn the rules that assure accuracy, and who has the patience to check and record the measurements accurately. In the past the principal trouble in the use of measurements has been that attention has centered on single observations of a child in relation to his peers. Since our interest is in growth, emphasis is now placed on the changes in successive measurements of the same child. It has long been common practice to take and record weights and heights of children, but these are frequently recorded without having any suitable means of interpretation. Appropriate practice today calls for plotting these measurements on charts, of which there are a number available (such as those Dr. Boyd has described), which permit interpretation of the child's progress in relation to his own past and to different patterns of growth encountered in various groups of children.

Another question concerns the effect of the many observations made on the children enrolled in long-time studies — upon their knowledge, habits, emotions, and so forth. It is generally agreed that these experiences affect children, as do all their other experiences, and that

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Dr. Harold C. Stuart, a specialist in pediatrics and in preventive medicine and public health, is professor and head of the Department of Maternal and Child Health at the Harvard School of Public Health, and visiting physician and head of the Child Health Division of the Children's Medical Center, Boston.

Dr. Stuart has been director of a study of child health and development at the Harvard School of Public Health during the past 20 years. In that study a group of children has been followed periodically from birth to maturity by representatives of different disciplines concerned with child development.

precautions must always be taken to make sure that these will be beneficial rather than otherwise. The staff of a study project is an important part of the child's environment, and hence the personality and the characteristics and the attitudes of the personnel to the children enrolled are of great importance. Everybody who participates directly in studies of this sort—and this is equally important for all who participate in health services for children — should be interested in people, be skillful in gaining their confidence, and have special competence in dealing with children.

After 20 years of experience in this field, I can recall several instances in which it was impossible to obtain useful information from the study point of view because of the emotional responses of either mother or child. When this has been recognized and satisfactory adjustment could not be made quickly, we have recommended that the child be withdrawn from the study. In the great majority of instances, however, we have recognized many ways in which the child and the family have profited from their associations with our research staff.

In the studies of health and development in progress at present at the Harvard School of Public Health, boys and girls are almost every week passing through their eighteenth-year comprehensive examination, which requires about three half-days and is the last routine examination scheduled. The expressions of appreciation, not only by the parents but by the children themselves, for the opportunities they have had with us, are most gratifying. This is not said in defense of such research, but rather to impress upon all workers in the field of child health that the experiences they provide can be beneficial beyond the limits of their specific purposes. It is said rather to call attention to the great need among all such workers for knowledge and understanding of children as individuals, and not merely of specific aspects of their health or development.

Reprints in about 6 weeks

IN THE NEWS

Foster parents need not pay income tax on money they receive from a child-placing agency to pay for a child's care. Also, the agency making such payments is not required to report them. This has recently been ruled by the Commissioner of Internal Revenue, in response to a request by the Acting Federal Security Administrator for an advisory opinion on the status of such payments. The ruling made it clear that the amount paid by the agency must not be greater than the amount spent on the child's care by the foster parents.

After a conference between representatives of the Children's Bureau, the Child Welfare League of America, and the Federal Security Agency's Office of General Counsel, the Acting Federal Security Administrator wrote a letter to the Commissioner of Internal Revenue, accompanied by a brief supporting the position that payments by child-placing agencies for foster care are trust funds for the child and not income to the foster parents.

In a letter dated October 5, 1951, informing the Acting Administrator of the new ruling, the Commissioner said:

"It is the opinion of this office that where the payment made by the child-placing agency is solely for reimbursement of expenses incurred by the foster parent in taking care of the child and is in an amount not in excess of such expenses, neither said expenditures nor the reimbursements therefor need be reflected in the Federal income-tax return of the foster parent and the child-placing agencies are not required to file annual information returns under section 147 (a) of the Internal Revenue Code with respect to said maintenance payments."

A cerebral-palsy institute will be held Jan. 21–Feb. 1, 1952, sponsored by the Coordinating Council for Cerebral Palsy in New York City. Further information from Miss Marguerite Abbott, Executive Director, 270 Park Ave., New York 17, N. Y.

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Jan. 4–5, 1952. American Group Therapy Association. Eighth annual conference. New York.

Jan. 17. Maternity Center Association. Thirty-fourth annual meeting. New York, N. Y.

Jan. 26–31. American Academy of Orthopaedic Surgeons. Ninteenth annual convention. Chicago, Ill.

Jan. 27–31. Third National Conference on UNESCO. New York.

Jan. 30–Feb. 2. American Association of Schools of Social Work. Thirty-third annual meeting. New York, N. Y.

New edition of Infant Care issued

Infant Care, which has been published as a guide for mothers and fathers ever since 1914, has recently been issued in its ninth edition.

We shall tell you more about is in our next issue.

For your bookshelf

(Continued from page 64)

icies should be reduced to a minimum. Development of national standards for juvenile services in police departments, as recommended by the Midcentury White House Conference, would be helpful in attaining coordination between agencies.

It is disappointing to note that in this good-sized report only two short paragraphs are devoted to the rights of children and of parents. These are mentioned in relation to the activities of the police. However, the comments on these would be equally applicable to an "authority-using bureau," the establishment of which is recommended by the committee. The role of the police in relation to detention of children is not discussed.

As a whole this report offers a thoughtful and thought-provoking evaluation of an important type of agency.

William H. Sheridan

Illustrations: Cover, Esther Bubley. Pp. 52–53, Philip Bonn.

THE CHILD

VOL. 16 NO. 4

DECEMBER 1951

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

The subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions. Single copies, 15 cents.

FOR YOUR BOOKSHELF

POLICE AND CHILDREN; a study of New York City's Juvenile Aid Bureau. By Alfred J. Kahn. Citizens' Committee on Children of New York City, Inc., 1407 Broadway, New York 18, N. Y. 1951. 83 pp. $1.

Most police departments in cities have special divisions for working with boys and girls who break the law or seem to be in danger of doing so. But we see few reports on the work of these divisions; and so this study of the Juvenile Aid Bureau of New York City's Police Department will be welcomed by all persons concerned with the welfare of children, especially those we label delinquent.

After discussing modern principles for dealing with juvenile delinquency and defining some police functions in this field, the report describes the Juvenile Aid Bureau. It tells how the Bureau developed, how it is organized, and how it operates. It classifies the children referred to it and the offenses for which they were referred. And it takes up the relations between the bureau and other community agencies.

The committee's recommendations for strengthening the city's program for helping children in trouble are next presented. Then come the comments of the Juvenile Aid Bureau on these recommendations, and the committee's reply to the bureau. The bureau and the committee agree on some of the recommendations, but disagree rather sharply on others; and considerable divergence appears on fundamental questions relating to the prevention and treatment of delinquency as well as to the functions of the law-enforcement agency.

There is growing recognition on the part of other agencies in communities of the fact that the law-enforcement agency has an important role to play in community programs for the protection of children and the prevention of delinquency. On the other hand, the law-enforcement agency must also recognize that it is only one of many agencies in the community concerned with children. If maximum effectiveness is to be achieved, differences of opinion affecting philosophy, objectives, and basic methods and pol-

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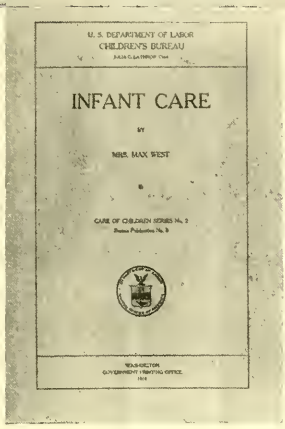
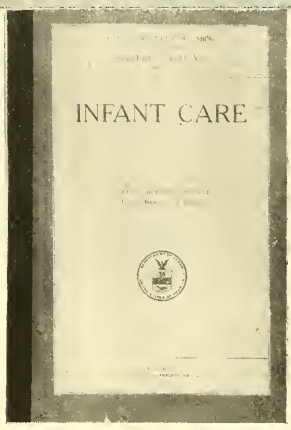
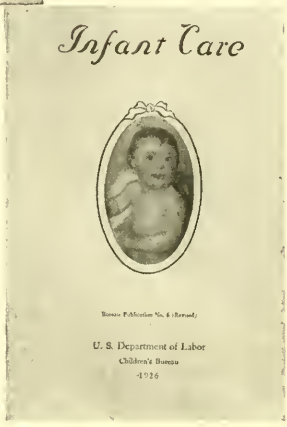
U.S. GOVERNMENT PRINTING OFFICE: 1951 952604

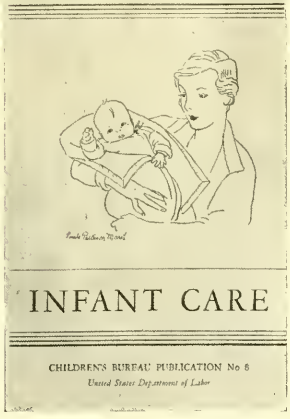
THE CHILD

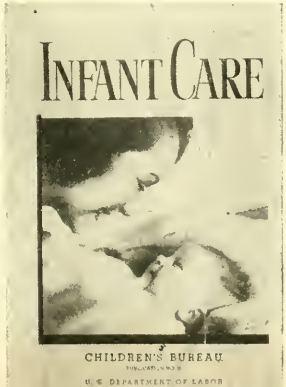
JANUARY
1952

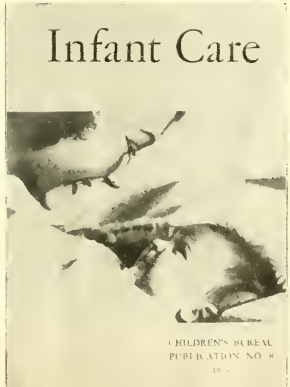












PARENTS WELCOME NEW EDITION OF INFANT CARE

ISSUED RECENTLY, the 1951 completely revised edition of Infant Care, the Children's Bureau "baby book," is already being used by thousands of mothers and fathers, most of whom were not born when the Bureau published the first edition, in 1914. Since that first edition came out, more than 28,000,000 copies of Infant Care in its various editions have been distributed, and it has been translated into eight languages. It has long been known as the Government's best-selling publication.

The principal authors of the new edition are Mrs. Marion L. Faegre, specialist in parent education, and Dr. Alice D. Chenoweth, pediatric consultant, both on the staff of the Children's Bureau.

A mother or father who expects to find strict "rules" for taking care of the baby will not find them in Infant Care. The booklet, of course, gives suggestions to help parents feed and bathe the baby and do the many other things that a baby needs if he is to be healthy and happy. But it sets its keynote in the chapter called The New Experience of Becoming a Parent when it tells mothers and fathers that the loving the baby gets is just as important as his physical care.

This chapter stresses the baby's individual needs as a person, and says that the way his father and mother fulfill these needs is tied up with the way they feed him and bathe him and dress him. The baby's emotional needs are truly met, the booklet says, when the parents give him the tenderness and affection that help him feel secure.

On the other hand, Infant Care makes clear that the parents are not to permit their own needs to be completely left out of account. Though it suggests that the baby be fed whenever he acts hungry, and that he be helped to develop his own feeding rhythm, it does not favor his ruling the household. If we really carried out "self-demand," the book observes, we could turn the baby into a tyrant, and that would make him far from happy in the long run.

Infant Care gives parents some credit. Note: "When you both feel light-hearted enough to enjoy your baby you are making a good start at building up reliance on your own judgment and common sense. No book or expert can ever tell you all about your baby. Only you two will get to know him well enough to be able to decide what to do in many cases. . . . You'll adapt what you have read and heard to fit your baby—a different person from every other baby in the world."

Throughout the pamphlet parents get a lot more attention than some people expect to find in a baby book. Thus: "A woman who is relaxed and not afraid will notice that her baby responds to her feelings and is easier to take care of. And a man who knows something about what to expect of a baby can sidestep his nervousness and enjoy his first-born sooner."

A father wants to have some part in the care of his baby, but he doesn't want it to be only the middle-of-the night floor-walking that is such a favorite of cartoonists." Furthermore, "The baby wants to know his father as a warm, comforting person."

Throughout the book the stress is on relaxation, comfort, and happiness.

Some people have noticed that early editions of Infant Care seemed to lay most of the emphasis on the physical health of the baby, and that this edition seems to pay more attention to his emotional health. That is to be expected, for in 1914, when the first edition was published, the most pressing problem concerning babies was to keep them alive. At that time, of every 1,000 babies born in this country an estimated

When both father and mother feel light-hearted enough to enjoy their baby they are making a good start toward building up reliance on their own judgment and common sense.

100 died in their first year—1 in 10. Now, fewer than 30 babies die per 1,000 born. Since medical science has increased the baby's chances for living, there's more opportunity to stress his happiness.

Before the new edition was undertaken, the Bureau staff discussed with professional workers in various fields concerned with children, as well as with parents, their ideas about what should be in the booklet. After the first draft was written, the manuscript was submitted for review to 70 persons. These included doctors (general practitioners, pediatricians, and psychiatrists), psychologists, nurses, nutritionists, anthropologists, social workers, parent educators, and parents. All the parents had babies less than a year old or were expectant parents.

As with previous editions of Infant Care, the Bureau was given invaluable help by its Pediatric Advisory Committee, whose members represent the Pediatric Section of the American Medical Association, the American Pediatric Society, the American Academy of Pediatrics, and the Society for Pediatric Research.

Between 1914 and 1951 the bulletin has been many times revised to keep up with advances in medical and other knowledge about how a baby grows and develops during his first year of life. Eight complete revisions have been published, and frequent minor changes made during the booklet's 37 years.

Whether the baby is nursed or bottle-fed is not so important as whether he gets enough food of the right kind; that he gets it when he needs it; and that he enjoys his meals.

How time has changed or confirmed ideas on the care babies need during the first year of life shows up when we compare the earliest edition of this book with the latest one.

For example, in 1914 vaccination against smallpox was the only type of immunization procedure mentioned in Infant Care. But as time went on, and doctors learned to protect babies from diphtheria, whooping cough, and tetanus by means of immunization procedures, the Bureau added recommendations on using these procedures.

Again, in 1914 doctors had not yet learned how easily rickets can be prevented. And so cod-liver oil is not mentioned in Infant Care until 1926.

In 1914, Infant Care suggested that babies be fed at 3-hour intervals until they were 6 months old. In 1951: "Letting a baby have a chance to develop a feeding rhythm of his own takes more judgment than feeding him at set intervals. But it's much easier than having an unhappy baby . . . . If you are not breast-feeding it means getting ready a good many bottles of formula, during the first few weeks, to be sure you will have a fresh one for him whenever he's hungry. It means giving careful attention to your baby to learn to judge whether he is hungry."

Some 1914 advice on the baby's food was that "the milk of each animal is different from that of every other, and each is especially adapted to the requirements of the young of that species. No other argument than this simple physio-

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Bath time is a good occasion for playing with the baby, talking to him, laughing with him.

WHO AND UNICEF HELP GOVERNMENTS TO IMPROVE MIDWIFE PRACTICES

RUTH CRAWFORD

MILLIONS of people in some Asiatic and Latin American countries live in jungles or forests, or on farms, where doctors and nurses are almost unknown, but where every village has its midwife. The midwife is the friend of the families in her village. She has their confidence; they seek her advice and they act on it. But most of them are untrained; and they follow such superstitious practices as putting cow dung on a newborn baby's navel, exhausting a weary mother with a thousand witchery spells, and even whipping a woman during labor. No wonder so many mothers and babies die.

In these economically undeveloped countries little money can be spent on public health. Typically the sum is 10 to 20 cents a year per person. But many of the governments are determined to use their meager resources in the most efficient ways to improve the health of their people. They have asked for help from the World Health Organization and the United Nations International Children's Emergency Fund so that they can get started in developing health services, especially those specifically planned for mothers and for children.

Teams of doctors and nurses sent by WHO and UNICEF are now working among the families in a number of countries, studying local conditions while providing services to families, in an effort to find the best ways of adapting health work to the special needs of the people. These teams are helping to establish centers for training native workers, and supervising them.

WHO gives technical assistance, and UNICEF provides supplies, such as equipment that will enable the doctors and nurses to use, for example, an existing hospital, or school, or clinic as a training center.

Home nursing visits sometimes require clothes that are suitable for climbing. This nurse, on the staff of the World Health Organization, is part of a team that is helping the Thai Government to lay the foundations for a health service in isolated regions. WHO and UNICEF are helping with the work.

A young midwife here carries her kit on her back. A large number of kits like this, containing all the articles needed for deliveries, are being sent by UNICEF to countries in Asia and Latin America. Trainees will use them while they are learning midwifery and after they go out to deliver mothers in rural areas.

At these centers the governments are striving to train young women from the villages to do simple midwifery. Extensive schooling is not expected of them; ability to read, write, and do a little arithmetic is all that is necessary. With this to start on, the young women are given 6 months of sound preparation —a maximum of practice and a minimum of theory. This, the governments believe, will train a conscientious, intelligent young woman to be a useful midwife.

Such a woman after her training is expected to be able to conduct normal childbirth, and she should be able also to teach expectant mothers how to take care of themselves in an effort to forestall abnormal delivery. The training should enable the midwife to recognize signs that point ahead of time to the fact that a delivery is likely to be abnormal, so that she can try to get help, or to send the woman to a place where help may be had.

The hope of the governments is that as the people of the villages see how many babies' and mothers' lives are saved through use of the new, clean methods, they will recognize the value of them and abandone the old, dirty methods.

To help and encourage the trainees, UNICEF is providing a number of midwifery kits, up-to-date and compact, each containing the articles needed for a delivery, as well as instructions for using them. The instructions, of course, are written in the language of the place where the particular kit is to be sent. A kit will be given to each trainee to use while she is learning and, after she returns to her village, to use in delivering women.

Along with her kit, each trainee receives a message from UNICEF. Part of this message reads as follows:

"The material in this kit is of first-rate quality. You will be careful that it is not damaged, broken, or lost; for besides being expensive and perhaps hard to replace, it is a contribution from the earnings of many working people like yourself in many parts of the world. You will value it for that reason."

The message continues:

"UNICEF has sought the advice of the World Health Organization and of experienced obstetricians and midwives in selecting the contents of this kit; UNICEF also seeks your advice and practical experience. Therefore we are enclosing a leaflet, which we beg you to fill out after you have used the kit for 6 months. Hand it to your local authorities or mail it to the UNICEF Mission [address given].

"UNICEF will welcome not only expressions of your satisfaction, but any criticism you have, and suggestions for the improvement of the kit. You may find that kits similar in design can be produced in your country with materials which although different may be equally useful."

This last statement, holding forth the expectation that the countries may be able to produce their own kits, conveys an idea that underlies this entire undertaking. UNICEF and WHO are merely giving the help that will enable the governments of the assisted countries to get health work started.

The countries scheduled to receive this type of help are Afghanistan, Burma, Ceylon, India, Indo-

(Continued on page 77)

Ruth Crawford is Public Information Officer, United Nations International Children's Emergency Fund. She was formerly with the Children's Bureau.

Here is a class of young girls who have received diplomas after a short course in simple midwifery. They have received training in modern methods of delivering women in childbirth, and when they return to their villages they will set a good example to midwives who are still following unsanitary practices.

Villagers learn about baby care from a pediatrician. At first the babies were brought in by the men, for the women traditionally did not leave their homes. Now the women come for prenatal visits, and later for advice about caring for their babies. WHO and UNICEF are helping the Pakistan Government start this work.

THE INSTITUTION AS THERAPIST

GEORGE E. GARDNER, Ph.D., M.D.

IT IS ACCURATE, I believe, to state that the community expects the institution to change the individual delinquent. It expects it to return him to the community a law-abiding citizen, with social, educational, and occupational aims and attitudes consistent with those expected from, demanded of, and expressed by the majority of youngsters of comparable age. The changes that it expects, then, are not changes such as the acquirement of specific skills or educational accomplishments, save in relation to the rudiments of interpersonal relationships.

In this context of our expectations we can, for purposes of discussion, consider the institution as a whole as a psychotherapeutic unit and proceed as if we regarded it as a therapist. I am not unmindful of the fact that an institution is a group of people, each with his or her own assets and shortcomings as a person giving treatment, but I am sure that you will allow me this excursion into a modified anthropomorphism so that I may stress the importance of attitudes and principles.

Let us proceed clinically in this institutional analogy and outline: First of all, the chief complaint; secondly, the therapeutic goal; and, finally, the therapeutic process as it evolves.

1. The chief complaint. I think it is a fair estimate that in 90 percent of delinquency cases the community's chief complaint is that the child is hostile and aggressive. Hostility and aggressiveness are apparent in that these children break and enter, steal other people's property, assault and damage, refuse to go to school, and resent the authority of the community and the home. Such is the chief complaint of society. It is manifest and vocal and it is expressed in the application of certain corrective and punishing restraints.

But the "chief complaint" of the child himself—the one in which the therapist-institution is primarily concerned—although parallel, is by no means so apparent and clear. It is for the most part hidden and covert. But long-continued intensive psychotherapy of individual delinquents has repeatedly given us data relative to these latent concepts, drives, and attitudes, and I shall cite them briefly.

The majority of our studies would indicate that the chief and nuclear personality defects in these boys and girls are brought about by their concept of the external world and the human beings in it, and their concept of self. The delinquent's concept of the external world is a world that is at all points aggressive, destructive, and primitive. By this I mean that for hundreds of "reasons" based on adverse interpersonal experiences of an extremely harsh — and at times almost psychopathological — nature, the delinquent's concept of the human beings in the world is that they are definitely not human in the sense that we believe them to be.

We need not go into the complex, highly charged emotional experiences in the early lives of these children that have led to the formulation of this concept. Suffice it to say that in their eyes, although they do not realize it, human beings have in great abundance the attributes, the attitudes, and the methods of operation of the predatory animal. Through their experience, delinquents in their earliest and predelinquent years have become highly sensitized to the expressed, and particularly to the unexpressed, hostility of which all human beings are capable; and they have, on the other hand, been deprived of those corrective emotional experiences that modify this sensitivity in the homes where children are genuinely wanted and unconditionally loved.

It is difficult for you and me to entertain a concept of a human being (every human being) as (as one delinquent adolescent revealed to me) a cobra that sways into a position to strike when any other animal (meaning himself) comes near. But it is not difficult for us to envisage what lack of warmth this boy, or ourselves, would reasonably expect from human beings if such was our concept of them — or, in turn, how much warmth could reasonably be expected of us in our dealing with such humans. Nor is it difficult for us to appreciate the difficulty such an individual has in identifying with adults, and the seeming ease with which he can identify with other persons, the major aspects of whose concepts are similar to his own.

I assure you that this is not an extraordinary or unexpected unconscious concept that this boy holds. It can be duplicated as typical of the nuclear human-being concept in case after case. This is the chief complaint of the delinquent

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Dr. George E. Gardner is Director of the Judge Baker Guidance Center, at Boston, and he is the editor of the American Journal of Orthopsychiatry.

Dr. Gardner presented this paper at the Berkshire International Forum, which met at Canaan, N. Y., under the auspices of the Berkshire Industrial Farm, with the participation of members of the United Nations Secretariat. The paper was part of a symposium on the mutual responsibilities of the community and the institution in the care and treatment of the juvenile delinquent.

In Dr. Gardner's paper he does not emphasize the role of the psychiatrist in the treatment program, nor outline specific and detailed modes of treatment. Rather, he aims to formulate, in the light of observations of delinquent boys and girls who have been treated individually, the general principles and fundamental attitudes within the institution that will constitute the emotional climate necessary if any specific methods of therapy are to be successful.

In a correctional institution for children it is an integral part of the job of a teacher, or housemaster, or administrator, to lead each child to understand what his behavior means.

himself, rarely recognized without guidance, voiced only under the stimulus of a treatment relationship, but nonetheless operative in his behavior with deadly and disabling repetitiveness.

Concomitant with this, and equally disabling in its behavioral expression, is the delinquent's own concept of self — again usually unconscious and unexpressed save in the treatment setting. His nuclear concept of himself is that he too is a hostile, aggressive, predatory animal, driven by urges he does not completely understand to wrest from this environment of humans whatever he can — either through mutilative or destructive methods or by a process of leechlike osmosis— or by both methods.

How he arrives at such a concept of self we in psychiatry are only now beginning to envision dimly; but we are convinced that this is a very prevalent concept, that it is due to development faults or arrests in what usually is orderly personality growth, and that it is just at this point (in relation to the concept of self) that the elements common to delinquent behavior and neurotic behavior are beginning to become apparent. It probably goes without saying, in this connection, that punishing an individual who has this self-concept not only will not alter the concept itself, but on the contrary will go far in confirming within the child the very attitude which is the motivation and source of power for his antisocial behavior. With such a concept of self, too, it is not difficult to explain the almost total lack of self-respect which is noted in our delinquents.

The presence of self-respect necessitates the internal concept of oneself as a worth-while human being together with the frequent demonstration of respect externally on the part of others acting like human beings. Unfortunately, we do too little at the present time to break this cycle of concept relationships by a treatment "attack" on the nuclear ingredients of both.

*2. **The therapeutic aim.*** Such is the "chief complaint" — the child's disabling concept of his external world of humans. It is our fundamental hypothesis that this is so. The therapeutic aim or treatment goal is to alter these concepts as speedily as we can in all cases, and as thoroughly as is necessary in the individual case.

The means by which these changes can be effected are varied, and none of them are easy. It would be fine, of course, if every delinquent were to be treated individually by a skilled psychotherapist. But you and I know this to be a practical impossibility. At the present time we can get but an approximation to this type of program, and in the majority of instances cannot get it at all. And this, for a number of reasons, is perhaps particularly true in respect to boys and girls who are remanded to correctional institutions.

However, it is apparent to me that the institution itself — its collective personnel — can go far in initiating these changes in concepts that seem to be so necessary. Whether or not the institution has enough specialized personnel, the institution itself can forward this psychotherapeutic process, and can and should do so, with an understanding of — and a conscious use of — some basic principles and steps in the treatment process that seem to operate in all psychotherapy — individual, group, or institutional. Let us look at the institution as therapist.

*3. **The institution-therapist.*** There are at least four well-definable steps in the psychotherapeutic process — any psychotherapeutic process — and the institution can orient and outline its total program, and particularly its over-all treatment philosophy, in respect to them.

(a) There is, first of all, the establishment of the optimal treatment relationship — the positive transference relationship, if you will. This positive relationship is, in its very essence, a noncombative and nonaggressive relationship. It is accepting and permissive, but not to the stage of unlimited freedom of individual expression and license that arouses a feeling of guilt. It is permissiveness broadly drawn, but fairly and consistently drawn, and the limits thereto are set at a point to control the child's own instinctual drives, which he himself fears, and to control the aggressiveness of his associated colleagues

and superiors, which he also fears. If the child is to alter his concepts of himself and others at all, such changes will only take place in a milieu—an institution, if you will—of such security and noncombativeness. Education and growth just will not take place save in the presence of security feelings.

(b) The second stage in the therapeutic process is the revelation or exposure of unconscious or only dimly conscious impulses, drives, and needs that govern our behavior with other human beings—those of equal status and those of authoritative or supervisory status above us. It might be thought that a cognizance of such impulses and of their efficacious or disabling effects upon our interpersonal relationships could be brought about only through long, intensive individual psychotherapy, and of course to a certain degree and in certain respects this is undoubtedly true. However, I submit that great numbers of individuals to whom a psychoanalytic procedure is not available—by the very fact of continued inevitable contacts with other people in groups — do arrive at an appreciable degree of insight as to their own underlying motives. Surely institutional living does no less—and perhaps can do more than ordinary life contacts, through its general and specific programs — to bring these impulses to self-attention. It is in the experience of all of us doing individual therapy with delinquents — though too infrequently — that youngsters have returned to us from institutions where individual work is at a minimum—to be amazed at the beneficial insights they have arrived at through group living in a correctional institution.

(c) A third element in the therapeutic process is technically referred to as confrontation and interpretation of our behavioral patterns. It is a making clear to us repeatedly of just what we seem to be trying to do. This, too, goes on apace in institutional living, whether we are aware of it or not. It is done wittingly or unwittingly by the child's associates at all times, and it is done by housemasters and teachers and administrators as an integral part of their jobs. The institution as a whole is a confronting and an interpretive agent, and all directing personnel within it should be aware of their opportunities to forward this aspect of the total institutional treatment process. As I suggested above, however, none of these broader educational elements of institution life will have a beneficial effect unless done in a nonaggressive relationship motivated by the desire to help.

(d) Finally, in the treatment process, comes the inevitable stage when trial and error learning must emerge—when the individual child will make the first tentative attempts to change his behavior through a modification of his previous concept of self and others. The institution in its programs—educational, social, athletic, vocational, and so forth, provides (or should provide) numerous opportunities for such trials, and its personnel should be alert to the initial endeavors of the child in change. Here in abundance are the need for and the opportunities for the application of those genuinely therapeutic devices of suggestion, advice, encouragement, sympathy at the time of failure, approval, prestige citation through work or house assignments — all these and many more whose value we are inclined at times to minimize. The institution can make for changes in self-concepts as noted above, and it also has ample opportunity to provide suitable outlets for the feelings that are expressed in trial behavior, and to guide those feelings.

Such, then, is the institution in its totality as a therapeutic unit, as the psychiatrist might view it. The chief complaints of the delinquent boy or girl are disabling concepts of self and human beings as a whole; the therapeutic aim is to change these concepts to the extent that both concepts include values truly human. The therapist is "the institution treating" — treating through all of the constructive personal relationships and through all of the activities that it is able to offer. And regardless of the presence of the highly skilled individual or group psychotherapists that we so sorely need, treatment success will only be assured when the institution is genuinely treatment-oriented.

Many a child arrives at beneficial insights through group life in a correctional institution.

Reprints in about 6 weeks

TOWARD THE GOALS OF THE MIDCENTURY CONFERENCE

MOVING full speed ahead in their efforts to provide conditions for furthering development of healthy personality in the children and young people of their own States and communities, thousands of groups have held meetings during the past 12 months to consider ways of carrying out the recommendations of the Midcentury White House Conference.

Plans for encouraging and guiding further progress by such groups crystallized recently at three national meetings. The National Midcentury Committee on Children and Youth and the Advisory Council on State and Local Action met in Chicago at the end of October. The Advisory Council on Participation of National Organizations met late in November, at New York.

Under the chairmanship of Leonard W. Mayo, the National Committee completed its plan of organization and nominated additional persons to be added to the committee. Among the new members is Katharine F. Lenroot, formerly Chief of the Children's Bureau. Two vice chairmen were elected, Dr. Benjamin M. Spock and the Very Rev. John J. McClafferty. Melvin A. Glasser, formerly Executive Director of the Midcentury White House Conference and now an Associate Chief of the Children's Bureau, serves the Midcentury committee as a consultant.

Continuing cooperation between public and voluntary agencies working with and for children was demonstrated by the presence of liaison representatives of the Federal Interdepartmental Committee on Children and Youth.

The work of the committee is to be financed entirely from voluntary sources. Currently its budget is being met from the balance remaining after the Washington conference and from a foundation grant. For the future, contributions are to be sought from foundations, national organizations, and individuals.

Substantial progress in follow-up activity was reported by Elma Phillipson, executive secretary of the committee. White House Conference materials are being used widely, some as texts in professional schools, colleges, and high schools, she said. In State conferences and local meetings, groups are promoting understanding of the White House Conference concepts as a basis for active follow-up of its recommendations.

The Midcentury Committee discussed and adopted a statement of basic purpose. Working primarily with and through existing agencies the National Midcentury Committee program aims (1) To disseminate the findings of the conference, (2) to stimulate action on its recommendations and on the Pledge to Children, and (3) to promote research designed to fill the gaps in knowledge brought to light by the conference. The committee itemized some of the methods that it is using to fulfill these purposes.

Specifically, the committee will continue to give consultation service to help State committees and national organizations apply the White House Conference findings. It will stimulate the development

of such program aids as discussion guides and visual materials. It will work to interest foundations and universities in needed research. It will promote participation by youth in programs for youth. It will spread the conference ideas by means of all the mass media. And it will exchange these ideas with other people throughout the world.

The meeting of the Advisory Council on State and Local Action included representatives of State White House Conference committees from 33 States, 2 Territories, and the District of Columbia. Of the remaining States, nearly all have committees that are working actively on follow-up of the Midcentury Conference.

How White House Conference findings can best be disseminated to parents and professional workers was studied by one of the work groups of the Advisory Council on State and Local Action. Among the methods outlined by the work group were: To discusss, rather than to offer lectures or reports; to break up material so that no group is offered more than it can handle at one sitting; to bring out into the open people's prejudices and other attitudes, especially race and religious prejudices; to select appropriate leaders as interpreters of White House Conference materials; to stress the normal needs and problems of children and youth; to recognize the State committees' limitations and share the responsibility with local groups; to concentrate on strengths in parents, in groups, and in the community as a whole.

Realizing that youth participation is past the experimental stage, the Advisory Council on State and Local Action devoted attention to ways of developing such participation. The council voted to give young people more voice in its policy-making—one-third of the voting members are to be young people. A work group on youth participation recommended that State committees include in their membership more out-of-school young people, more from various income levels, and more of various faiths and races.

The importance of keeping the public informed about the follow-up activities of the Midcentury Conference was stressed by another work group of the advisory council on State and Local Action. State committees were urged to simplify and popularize their information material and to exchange information with each other and with the National Committee so that all will know more about what is happening to children, what are their problems, and how these problems are being met.

Representatives of over 100 organizations attended the meeting of the Advisory Council on Participation of National Organizations. Having reorganized to serve in an advisory capacity to the National Midcentury Committee for Children and Youth, the council elected the following officers: Robert E. Bondy, chairman; Lyle Ashby, vice chairman; George B. Corwin, vice chairman; and Mrs. Deborah Partridge, secretary.

The council approved a number of plans for activities designed to reinforce the program of the National Committee. Among these plans, to be carried out by the council and its member organizations, are: To review organization programs in the light of conference

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WE ACCEPT THE CHALLENGE

LEONARD W. MAYO

WE of the National Midcentury Committee for Children and Youth feel that these meetings have brought to each of us a fuller understanding of the big and serious task ahead, and we are encouraged by knowing that so many people wish to take an active part in this move for the further strengthening of democracy.

We are fully conscious of our great obligations in carrying out the program assigned to us. We are aware that as individuals and as committee members we must be farsighted, foresighted, and statesmanlike.

Previous speakers have given voice to the challenge confronting us, and in behalf of the National Committee I accept it. In the same breath I invite all of you to share the responsibility for accepting this challenge, and along with it the joys and the sacrifices involved in moving forward for the children and youth of the Nation.

We know that in our efforts with community groups and committees, and in our attempts to build programs for children and youth, there will be times when we are sorely tempted to attack those who oppose us. Our good sense and better judgment will tell us, however, that for every time it is appropriate to attack, there will be ninety-nine times when it is more appropriate to think, to weigh, and to approach our opponents with a calm and determined diplomacy. We must learn to "act like thoughtful men," as Thomas Mann has said, "and to think like men of action."

After World War I, H. G. Wells said, "Civilization is a race between Education and Catastrophe." Alluding to that quotation, a friend of mine recently wrote, "I'm betting on Catastrophe."

This reaction of a sensitive mind to the pressures and realities of the times leads me to ask: What may we bet on as we face an uncertain future? What are the lasting, the enduring, the eternal values? To what may we hold with a sureness and a certainty that will make our efforts worth the candle? What can we convey to our children and youth that will keep their faith strong?

Unless we can find an answer that gives some semblance of satisfaction to ourselves, our work will have only a transient and superficial value.

The answer, I think, is found in the classic and religious writings of every age and of every great civilization, in the works of every great philosopher, and indeed of every great scientist. It boils down to this —that while empires and civilizations rise and fall, wars destroy, and the physical body is reduced to dust, the human spirit itself is indestructible. Here is a value that endures.

Anything we do, therefore, to aid mankind in his struggle to understand and control himself and to nurture his spirit is a contribution of profound and lasting importance. We can invest ourselves and all our powers with conviction and zest in such a cause, for it is one that prevails in an otherwise uncertain world.

If we are to bet on the future, then, we cannot overlook the indestructibility of the human spirit, nor the fact that he who gives of himself to add to the stature of others makes a contribution of lasting value to the children and youth of this and coming generations.

First, in the task we face, it must be one of our resolves that insofar as it lies within our power to prevent and protect, no child anywhere shall stand alone; in the second place, we know, as adults, that in terms of our responsibilities and obligations it is precisely how **we** shall stand, for each of us will be judged as individuals as to how he has conducted himself in this critical period in the world's history. It will one day be written whether we have lived up to the hilt of our convictions, whether we have met the challenge of these times with gallantry, with courage, and with steady faith.

Leonard W. Mayo is Director of the Association for the Aid of Crippled Children (of New York State). Previously he was Vice President of Western Reserve University, and, before that, Dean of that University's School of Applied Social Science.

Mr. Mayo is well known to readers of The Child as a member of Children's Bureau advisory committees. He was chairman of the National Commission on Children in Wartime and of its successor, the National Commission on Children and Youth.

He was a Vice Chairman of the National Committee, Midcentury White House Conference on Children and Youth, and Chairman of its Executive Committee. He is now Chairman of the National Midcentury Committee for Children and Youth.

For a number of years Mr. Mayo was President of the Child Welfare League of America, and is now a Vice President.

This article has been excerpted from remarks made by Mr. Mayo at a dinner held by the National Midcentury Committee for Children and Youth at Chicago October 30, 1951. Besides the members of the National Committee, those present included delegates to the Advisory Council on State and Local Action and representatives of national organizations and Federal agencies. Mr. Mayo spoke as chairman of the committee, in reply to "A Charge to the National Midcentury Committee for Children and Youth," presented by five speakers representing different points of view.

Reprints in about 6 weeks

INFANT CARE

(Continued from page 67)

logical one should be needed to induce a thoughtful mother to nurse her baby at the beginning of his life. . ."

The 1951 edition says: "Whether your baby is nursed at the breast or fed from a bottle, your concern will be to see that he gets enough food of the right kind, that he gets it when he needs it, and that he finds taking food enjoyable. . . It is the spirit in which you feed your baby that counts, rather than the particular kind of milk he gets."

In 1914 babies didn't get a chance at even a tablespoonful of strained fruit juice until they were 7 or 8 months old. The 1951 baby is getting 2 ounces a day by the time he is 2 months old. The 1914 baby couldn't have solid foods "other than soft egg, crisp toast or swieback," during his first year. The 1951 edition states, "Your doctor will decide when your baby needs solid foods in addition to milk. Some start giving these extra foods when a baby is only a few weeks old; others wait until babies are about 3 to 4 months old."

Thumb sucking came in for sharp criticism in the early editions of Infant Care. The 1914 edition even recommended pinning the sleeve of the baby's jacket down over the "fingers of the offending hand for several days and nights" to stop thumb sucking. This attitude has been increasingly modified, until in the new edition: "Sucking is the first way a baby gets pleasure. So when he is tired, or hungry, or doesn't have anything interesting to watch or to do, he may try to get a little pleasure out of his thumb or fingers. Sucking is a poor substitute for being held, or talked to, or fed; but it is better than nothing. And sometimes, mothers say, it seems to result in a very satisfied child."

In 1914, on the basis of what we knew then, mothers were told that the baby "should be taught to use the chamber" by the third month or even earlier. But the 1951 edition counsels patience: "A child can get to feeling that his mother is his enemy if she urges on him things he is not ready for. . . If you consider all that must go into learning bowel control, you won't be in such a hurry to expect your baby to act 'civilized.'" Sometime between one and a half and two years is suggested as a "much more common time" for babies to learn bowel control "willingly."

One unchanging philosophy throughout all editions of Infant Care has been that babies need tender, loving care to help them grow into healthy, happy children.

A baby wants to know his father as a comforting person; father wants to be close to him.

MIDCENTURY

(Continued from page 74)

findings and recommendations; to encourage action programs based on the recommendations; to remind the organizations periodically of the conference objectives; to encourage publication of material for lay members which relates the conference concepts to organization programs; to develop exhibits for national meetings.

Other efforts include: To encourage programs by local affiliates of national organizations; to select an annual period for drawing attention to the needs of children and youth; to provide speakers for White House Conference follow-up meetings; to prepare a check list showing what each national organization can do for follow-up of the conference; to pool the influence of the organizations in obtaining the cooperation of national publicity media; to encourage multidisciplinary and interagency cooperation in planning programs; and to establish a pilot study in a community to learn how the programs of national organizations affect community programs.

In the field of research the council advocated that its members review research that is under way and point out areas that need further research; pool the organizations' efforts to promote needed research; and hold meetings to inform the members of knowledge obtained from research and to stimulate its application in organization programs.

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"We believe that only by working together with adults on common concerns can youth acquire the knowledge and skills necessary for their future responsibility, and only in this way can the adult community really know and understand the needs, interests, and thoughts of young people."

—Arnulf M. Pins, President, Young Adult Council, National Social Welfare Assembly, New York, N. Y.

MIDWIVES

(Continued from page 69)

nesia, Pakistan, Philippines, Thailand, North Borneo, Brazil, and Colombia.

By and large, these countries have relatively few doctors: In Indonesia, for instance, there is only one doctor for every 70,000 people. What doctors there are, in those parts of the world as elsewhere, tend to congregate in the cities. What is true of doctors is even more true of trained nurses and trained midwives; in fact, in some countries tradition is set against women leaving their homes to enter these professions. Pakistan, for example, is now exerting a major persuasive effort to get young girls of the educated classes to set the example by going into training; those who respond have more than ordinary courage.

But even if the candidates were available in sufficient numbers to meet the needs of the great Asian population, there would still be the problem of where they could be trained and who would teach them.

To carry the problem one step further, even if medical personnel were to be trained in sufficient numbers, and even if they were willing to leave the cities, as matters stand now they would find it difficult to put their training to use among the countryfolk where their work is most needed, for a health service in those rural communities is practically nonexistent. They would have to accommodate themselves to the most primitive surroundings, build quarters, rig up equipment, obtain supplies, and then seek to win the people's confidence — a long and uncertain trail that would discourage most.

In the meantime, the governments expect that the newly trained midwives, returning to their villages, will be able to save some mothers and babies' lives and promote better health for them in the future. If the midwives are successful in these countries, the way will be opened to other health workers.

IN THE NEWS

More babies born. Almost 7 percent more babies were born in the United States during the first 8 months of 1951 than in the same period last year, according to the Public Health Service, Federal Security Agency This is not as many as were born in the first 8 months of 1947, the peak year for births so far, but it is only 0.9 percent below it. All sections of the United States shared in the increase in births.

At the same time, a cut of 1.4 percent was achieved in infant mortality. Deaths under 1 year per 1,000 live births in the first 8 months of 1950 and 1951 were, respectively, 29.3 and 28.9 (provisional figures).

Sodium fluoride. The number of cities in the United States adding sodium fluoride to their water supplies in an effort to reduce tooth decay in children has more than doubled during the past year, according to a compilation prepared by the Division of Dental Public Health, Bureau of State Services, Public Health Service. The 1951 figures show 121 communities with fluoridation programs in effect as compared with 50 communities at the same time in 1950. An additional 138 communities have approved a fluoridation program. The programs either are in effect or have been approved in 43 States and the District of Columbia, and involve an estimated 3,000,000 people.

Fact finding digest revised. Another edition has been published of the Digest of the Fact-Finding Report to the Midcentury White House Conference on Children and Youth. The revised report is titled "A Healthy Personality for Every Child." Three additional sections are included. One of the new sections is on Leisure-Time Services. Another discusses Services to Children With Physical and Mental Limitations. The third new section takes up Vocational Guidance and Placement Services, along with Child Labor and Youth Employment. (These three sections, in mimeographed form, were distributed at the December 1950 sessions of the conference.)

The revised edition is published by Health Publications Institute, Inc., 216 North Dawson Street, Raleigh, N. C., a nonprofit corporation. Single copies, $1 each. Lower prices on quantity orders.

Nutrition of mothers. Just how nutrition affects the condition of women before and after pregnancy, and of their babies as well, will be investigated under a grant made to a staff member of the Vanderbilt University School of Medicine, Nashville, Tenn. under a grant from the Public Health Service, Federal Security Agency. A large number of pregnant women, who have chosen their own diets, will be tested periodically throughout pregnancy and afterwards, and their health will be evaluated. Some studies made with experimental animals have indicated that both mothers and offspring have benefited through more abundant diets or diets supplemented with various nutrients during pregnancy.

Manpower. Although the total United States population has grown by more than 20,000,000 since the 1940 census, the number of males entering age 18 is, because of the low birth rate during the thirties, almost one-fifth lower than in 1940, and will exceed the 1940 level only after 1958.

Greece. A shipment of 100 tons of fruit, a gift from the Government of Greece, has arrived at Beirut, Lebanon, for use in a program of aid by the United Nations International Children's Emergency Fund (UNICEF) for mothers and children in Middle East refugee camps.

With the gift, valued at $25,000, the Greek nation—itself a recipient of UNICEF aid—has given other countries some $47,000 worth of assistance.

Philippines. The Government of the Republic of the Philippines has contributed 400,000 pesos, equivalent to $200,000, to the United Nations International Children's Emergency Fund (UNICEF).

This contribution will enable UNICEF to claim $514,000 in match-

ing funds from the balance still remaining of the United States appropriation of $75,000,000. Under this appropriation, the United States provides $2.57 for every dollar directly contributed by other governments to the work of UNICEF.

FOR YOUR BOOKSHELF

MATERNAL NUTRITION AND CHILD HEALTH; an interpretative review. By Kirsten U. Toverud, Genevieve Stearns, and Icie G. Macy. Bulletin of the National Research Council No. 123. National Academy of Sciences, Washington, November 1950. 174 pp. $2.

Prepared for the Committee on Maternal and Child Feeding, of the Food and Nutrition Board, National Research Council, this bulletin reviews studies from many countries that point to a positive relationship between the nutritional status of the mother in the preconceptional and prenatal periods, the development of the fetus, and the health of the infant. The authors think that there are sufficient indications that nutritional factors may play a part also in fetal wastage, prematurity, and congenital defects to warrant further studies along these lines.

Section 2, the longest of the three sections of the bulletin, deals with specific nutritional factors in maternal and child health. In this section, studies carried on by physicians, biochemists, and others during the past 25 years are reviewed, as they throw light on many aspects of maternal health. The first section reviews the progress in reducing maternal and infant mortality in most parts of the world during the period for which vital statistics are available. The last section, on prematernal, prenatal, and postnatal care, considers ways in which knowledge gained from research is being applied in the care of mothers and babies and points out areas where additional studies and programs are needed. Emphasis is placed on the value of interprofessional cooperation. The bibliography of more than 1,000 references gives some idea of the late Dr. Toverud's comprehensive knowledge of the subject that led her to her oft-quoted conclusion: "The child is nutritionally 9 months old at birth."

Ruth Doran, R.N., and Marjorie M. Heseltine

SUMMER'S CHILDREN; a photographic cycle of life at camp. Introduction by Mary Fisher Langmuir. Morgan and Morgan, Scarsdale, N. Y., 1951. 159 pp. $7.50.

Anyone whose duty, or pleasure, it is to take pictures of children in camp, or to select such pictures for use in public-relations work, can learn much about good photographs from this book. It offers more than 200 large pictures of children engaged in various camping activities. Many of the pictures include animals. Every picture in the book is natural and delightful.

UNRAVELING JUVENILE DELINQUENCY. By Sheldon and Eleanor Glueck. The Commonwealth Fund, 41 East Fifty-seventh Street, New York 22, N. Y. 1950. 399 pp. $5.

This report by the distinguished research team, Sheldon and Eleanor Glueck, of 500 delinquent and 500 nondelinquent boys, gives the results of a statistical study in which the authors searched for differences in characteristics that might have led to the delinquent behavior.

For the purposes of the study, the Gluecks use the term "delinquent" to refer to a boy older than 7 years and less than 17, who has repeatedly committed acts that would be crimes (either felonies or misdemeanors) if committed by a person past the statutory juvenile-court age of 16. Freedom from delinquent behavior was determined by checking court files to be sure that the boy had no court record, and, in doubtful situations, by questioning his parents and older brothers and sisters. This was in addition to a psychiatrist' s interview with each boy. In case of further doubt, inquiries were made among local police, social workers, recreational leaders, teachers, family doctors, and others in a position to know about the boy's activities. Occasional or accidental misbehavior was ignored.

The boys in the two groups were matched in pairs, according to age, general intelligence, national origin, and residence. (In each pair both boys were from underprivileged neighborhoods.) By various techniques, differences were then sought between the two groups. Family backgrounds and relationships were studied; also social and cultural influences; health and physical development; school histories, including likes, dislikes, aptitudes and achievements; and emotional and personality development. The authors used the marked differences discovered in constructing "predictive instrumentalities on the basis of which it should be possible to differentiate between potential juvenile offenders and nonoffenders very early in life, preferably at school entrance." Early identification of potential delinquents, the investigators felt, "would make possible the application of treatment measures that would be truly crime-preventive."

One serious weakness in the design of the Glueck study rests in its selection of delinquent boys, nearly all of whom were boys who had been committed to one of the two State training schools for boys in a single State. This could hardly be called a representative sample of delinquent boys. Selection of boys for institutional commitment is influenced by family relationships and resources, social histories, and the results of diagnostic procedures. The fact that they were committed and their experience in such a school are factors that certainly condition their social attitudes and reactions. What was determined then to be characteristics of this group in terms of family relationships and background, attitudes, reactions, and health and physical development cannot be assumed to be characteristic of all delinquents, but only of a group similarly selected.

The predictive tables presented by the Gluecks are interesting, but they would appear to need extensive testing to determine their validity. The study established the characteristics wherein the delinquents differed from the nondelinquents only as concomitant with, and not necessarily causative to, the behavior of a highly selected group of delinquent boys. To assume that these same differentiating characteristics would serve to identify potential delinquents among children of tender years would seem a highly speculative leap.

This criticism is not meant to obscure the values of this study. To a field that is often subject to the free play of unsubstantiated opinion and theory, this study contributes a wealth of factual data derived from a carefully planned research project of no mean dimensions. Some of its findings give factual substantiation to concepts we have long held. The intrafamily relation-

ships of the delinquent boys, for example, were markedly less constructive than were those of the nondelinquents.

Some of the findings are challenging and suggest leads for further research. Some may be surprising to many readers. Fewer of the delinquents than of the nondelinquents, for example, displayed neurotic trends. This supports the view that therapy with the adolescent delinquent should be directed toward improving control of instinctual drives; and it should jolt persons who consider the uncovering and resolution of personality conflicts as the cure-all for delinquency.

For those interested in the treatment of the delinquent the strengths found to be characteristic of the delinquent should be of particular interest and value. Perhaps, in our treatment programs, we have too often concentrated upon the delinquent's weaknesses, failing to turn to account and build upon his strengths. Many traits found by the Gluecks to be characteristic of the delinquents represent such strengths. The delinquents, for example, were found to be more outgoing, more self-assertive, more prone to express themselves in a direct, immediate, and concrete manner, and less fearful of defeat than the nondelinquents. These are among the traits that we should be able to take advantage of in developing treatment techniques and programs.

Richard Clendenen

THE FAMILY SCRAPBOOK. By Ernest G. Osborne. Association Press, New York, 1951. 457 pp. $3.95.

Prof. Ernest Osborne's "Family Scrapbook" of short pieces that originally came out in a newspaper column seems, at first glance, to offer just homely wisdom, based on experience and common sense. Studying the book a little more closely, we realize that these "scraps" express the results of research on child and family life, as well. Many phases of child rearing, from infancy up, are touched on. By dividing them into fractions small enough to deal with in a daily column, and by arranging them in orderly progression, the author has kept them from seeming fragmentary.

Through Dr. Osborne's casual references to his own childhood and his children's, and because he always makes it clear that it is "we," not "you," that he is talking about, the reader gets a feeling of intimacy with him. To those who are tired of having their blind spots and mistakes pointed out to them, it may come as a welcome surprise to have an author talk **with** them and not **at** them—an author, too, who demonstrates that he is a practicing parent, who has fun on the job, yet is not afraid to admit his own shortcomings.

In the sections on simple indoor and outdoor pastimes, parents will find all kinds of concrete answers to that perennial question, "What shall we do now?"

Marion L. Faegre

FEARS OF CHILDREN. One of a series of Better Living Booklets. By Helen Ross, Administrative Director, The Institute for Psychoanalysis, Chicago. Science Research Associates, Inc., 57 West Grand Avenue, Chicago 10, Ill., 1951. 49 pp. Single copies 40 cents; three for $1.

What causes fears in children? And how can parents and teachers help children to overcome their fears? This booklet offers accurate facts, as well as understandable discussion of these questions. The author describes the origin of various fears, such as fear of the loss of love, fear of separation from mother, fear of the dark, and fear of being "bad." She tells us how some fears are useful, since they help the child to avoid bodily harm, but notes how some fears may develop into feelings of anxiety that can cripple the child's personality.

The nervousness, timidities, and inhibitions of the adolescent, she says, are traceable to the same feelings that are common to younger children: The need to be loved, the wish to protect the body from harm, and the desire to get along with others and with one's own conscience. Her closing chapter, "How parents and teachers can help," includes sound recommendations, such as: Encourage questions; Talk over disturbing events; Don't reexpose a child to fear; Look for the underlying cause; and Examine your own feelings.

Harold E. Mann, M.D.

To Our Readers—

We welcome comments and suggestions about **The Child.**

Illustrations:

Our January cover represents nine editions of Infant Care, issued between 1914 and 1951.

Pp. 66, 67, 71, and 76, Philip Bonn for Children's Bureau.

Pp. 68 and 69, courtesy of United Nations International Children's Emergency Fund.

P. 72, Esther Bubley for Children's Bureau.

P. 73 (seal of the Midcentury White House Conference on Children and Youth), drawing by William N. Thompson.

P. 74, Esther Bubley for CIO-UAW.

THE CHILD

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

CALENDAR

Feb. 4. National Children's Dent Health Day. Fourth annual ob servance. Information from Bu reau of Public Information, Amer ican Dental Association, 222 Eas Superior Street, Chicago 11, Ill.

Feb. 6–12. Boy Scout Week. Fo ty-second anniversary. Informa tion from Boy Scouts of America 2 Park Avenue, New York 16 N. Y.

Feb. 10–17. Negro History Week Twenty-sixth annual observance Information from the Associatio for the Study of Negro Life an History, Inc., 1538 Ninth Stree NW., Washington 1, D. C.

Feb. 17–24. Brotherhood Week Annual observance. Sponsore by the National Conference o Christians and Jews. Informa tion from the National Confer ence of Christians and Jews, 38 Fourth Avenue, New York 16 N. Y.

Feb. 25–27. American Orthopsy chiatric Association. Twenty ninth annual meeting. Atlanti City, N. J.

Feb. 27–Mar. 1. Community Chest and Councils of America. Thir ty-third national biennial confer ence. Milwaukee, Wis.

Feb. 28–Mar. 1. National Confer ence on Rural Health. Commit tee on Rural Health, Americar Medical Association. Seventh annual conference. Denver, Colo

Area conferences, National Child Welfare Division, American Legion

Feb. 1–2. Area B—Delaware District of Columbia, Maryland New Jersey, New York, Pennsyl vania, Puerto Rico, Virginia, and West Virginia. Charleston, W Va.

Mar. 6–8. Area C—Alabama Arkansas, Florida, Georgia, Ken tucky, Louisiana, Mississippi North Carolina, Oklahoma, Pan ama, South Carolina, Tennessee and Texas. Little Rock, Ark.

Mar. 14–15. Area A—Connecti cut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Portland, Me.

Regional conference, Child Wel fare League of America:

Feb. 6–8. Eastern Regional Con ference. Philadelphia, Pa.

U.S. GOVERNMENT PRINTING OFFICE: 1951—95260

THE CHILD

FEBRUARY
1952

FOR THE CHILD WHO MUST LIVE AWAY FROM HIS OWN HOME

SPENCER H. CROOKES

ALL OVER the United States child-care agencies are making sound progress in improving foster care for children—care of the child outside his own home, whether in an institution, a boarding home, or the home of a family that plans to adopt him.

The great need that still exists for such care shows that we have not yet succeeded in carrying out the principle set by the first White House Conference on children (1909). That conference declared that "home life is the highest and finest product of civilization," and urged that "children should not be deprived of it except for urgent and compelling reasons."

Home life, said the first White House Conference, is the highest and finest product of civilization. Children should not be deprived of it except for urgent and compelling reasons.

To keep children in their homes

It is true that the Federal-State program of Aid to Dependent Children is taking a long step toward carrying out that principle, for it is now keeping more than a million and a half children in their own homes who otherwise would have to be placed elsewhere. [See Jane M. Hoey's article in this issue of **The Child**, "Aid to Dependent Children Keeps Homes Together."—ED.]

But pressure of numbers still confronts children's agencies.

The United States now has more than 47 million children under 18 years of age, the largest child population in our history. The birth rate is continuing to rise.

More women with children are entering employment. Family breakdowns seem to be increasing. And the housing shortage has added to the need for foster care for children.

In 1950 about 7 million children under 18 were living with only one parent or with neither parent—the majority of these children from families disrupted by death, divorce or separation.

As early as 1945 we began to see a change in the problems of the children that need foster-care services. More difficult problems appeared, problems that increasingly reflected parental incapacity or irresponsibility. A greater proportion of the children came from broken homes. This change has been leading to changed types of services.

SPENCER H. CROOKES is Executive Director of the Child Welfare League of America, the national voluntary federation of private and public child-welfare agencies.

This article was based by Mr. Crookes on a paper that he gave at the seventy-seventh annual meeting of the National Conference of Social Work.

New types of services needed

Right now we find that more children than ever before are presenting problems that do not respond to traditional methods, that our funds in inflated dollars will not pay for the increased and improved services that these children need, and that the public's lack of information about such conditions makes it difficult to obtain the necessary services.

As to the attitude of the public toward foster-care services, we see a tendency on the part of the people as a whole to link in a single mental picture both voluntary and public services. Thus, the growing concern over "extension of welfare pro-

grams" tends to depress, in both types of agency, already insufficient services for children.

Good child care has become increasingly expensive; and there is little likelihood that the expense can be reduced. The people have not been sufficiently informed as to what services are required for good child care; and so they do not realize how much it costs.

In community after community we of the Child Welfare League find that the vast majority of people continue to think of child welfare in terms of "orphans" or "homeless waifs." They do not know what we mean when we refer to a good foster-family program, and few indeed know the basic tenets of good institutional care and of adoption. In addition, they believe that any well-intentioned individual who likes children can carry out the highly skilled techniques that go to make up specialized child-welfare services.

We have failed to explain such services to the public, and we have failed to make clear how important are adequate grants of Aid to Dependent Children and adequate case-work service in such aid and in general public assistance. And as a result we have compounded our foster-care problems. The blame for such failures rests with no one group; we are all at fault for having failed to keep the public informed.

Institutional care now fitted to individuals

Increasingly, institutional care and foster-family care are recognized as complementing each other in a child-welfare program. We see signs that both institutional people and those sponsoring other forms of foster care are willing to change. The latter now say to the institutions in effect: "We appreciate the place that group living has in child care; we urgently need your help in handling children who would benefit from that kind of setting."

We went through a long period during which the sponsors of foster-family care heralded the end of institutions. Institutional people were inclined to withdraw behind their walls and to divorce themselves from planning and responsibility for community programs in general. Today we see a renaissance, in which institutions are undertaking to care for children with special emotional and behavior problems in ways that seem to tend toward direct diagnostic study and treatment. There is now hardly a community of over 250,000 population that has not, or is not seeking, special treatment programs for such children, as a result of the requests of social agencies. Many such programs, it is true, do not have the basic resources that are needed. Nevertheless we know that institutions will continue to treat children with problems.

Satisfactory general categories have been established as to the kinds of children needing institutional placement. For example, we have gone beyond the point of believing that all adolescents respond well to institutional care. Choosing the kind of help children need depends upon knowledge of the individual child and his situation. And choosing the place to send him for this help depends on what the available institutions or other resources have to offer.

In line with the present use of the institution, congregate buildings are being replaced, wherever this is possible, by cottages. Until recently, cottage units of 10 or 12 children were the smallest considered. Now some institutions are considering units that would provide for as few as 6 children; here, increased costs of program and staffing demand careful selection of children for this type of care, on the basis of their special needs. Some institutions have remodeled their congregate buildings as apartment units, which offer some of the advantages of the cottage plan as well as those of a congregate building. These units include not only bedrooms, but also living rooms and dining facilities, served by small kitchens.

Along with this changing emphasis in the use of institutions for specialized types of group care has come an increasing consciousness that until a different status can be achieved for the cottage parent in an institution, specialized programs are all but dreams. What is involved here is not only to redefine the job of houseparents so that each is an associate in the task of caring for children, rather than simply an overworked custodian, but also to establish adequate rates of pay, and, especially, to offer training programs that will help them to know more about children. A cottage parent needs not only managerial ability and qualities of leadership, but also the ability to understand children and their behavior in special circumstances.

It is not only by chance that one of the most consistent demands made of the Child Welfare League has been for training programs for houseparents, providing more than brief refresher institutes. A few such programs have been worked out, but they merely scratch the surface of the need.

Fewer children in institutions

Another factor that has contributed sharply to changes in institutional programs has been the decrease in the number of children in institutions. This has been largely the result of extension of other types of community resources, including foster-family care and provision of financial assistance and service to children in their own homes. Also agencies are doing a better job of selecting the children who can profit best by institutional experience. The institutions also realize how inefficient it is to use their costly facilities for custodial care of children who can be cared for better in selected foster-family homes.

Another development is that fewer babies and preschool children are placed in institutions. A policy long believed in by the League has been more and more widely accepted—that babies need the individual kind of care usually to be had only in a family home.

Also, the belief that case work is an essential part of the program of a good institution has found new adherents. This is not to say that all institutions either accept modern institutional methods or even admit that case work can play a role in effective institutional care. But we of the League are being called upon more than ever before to consult with institutions anxious to change to the best methods known.

What of developments in foster-family care? Of the thousands of children cared for outside their own homes, whether placed by voluntary or by public agencies, an increasing proportion are in foster-family homes. Many agencies are now introducing foster-family care as an adjunct to an institutional-placement program. Some family-welfare agencies are adding child-placing services to their functions. Another factor in the increasing use of foster-family homes is the greater availability of boarding homes, a result of improved agency staffing and higher payments for board. It is estimated that not less than 55 percent of the children cared for outside their own homes are in boarding homes.

Of the many other developments in foster-family care, three should be noted:

Emphasis is being placed on programs for recruiting foster homes. Although increased boarding rates and additional staff have made more homes available, a dearth continues. Housing shortages, costs, and higher incomes are given as causes, and some people think the saturation point has been reached.

Experience of agencies planning recruitment shows that we should keep several factors in mind: (1) Foster-home recruitment should be sustained if it is to be effective. (2) Staff time must be allocated for the purpose of following up queries. (3) Volunteers can be used effectively in home-finding campaigns to explain the situation, if given training. (4) Accompanying recruitment should be activities geared to give status and recognition to the foster parents, both as a means of making foster care understood and also of utilizing the best recruiters of all — the foster parents themselves.

Stress value of good foster parents

In an effort to keep good foster homes, agencies are emphasizing the part of foster parents in the over-all social services. Like cottage houseparents in an institution, who are charged with 24-hour responsibility for care and emotional nurture of children, foster parents are key figures. A successful foster-home program cannot be operated on a "place-and-run" basis. Agencies are accepting more responsibility for their share in the life of the child in a foster home, and are undertaking case work with the parents. They are also recognizing the special contributions of foster parents. I suspect that many good foster homes would not be lost if we helped them enough with the care of the children we send them, many of whom are bursting with problems.

Just a word about board rates. Information at the League indicates a steady increase in most parts of the country. The range is from $25 to $65, which means that in some places rates are below actual cost of care, and in others small service fees are being added to the actual costs. A firm conviction of the importance of reimbursing foster parents, at least for the actual cost of care, is growing. The obvious truth is that they cannot be repaid for the time, effort, and nervous energy involved.

Another development in foster-family care is the increasing use of subsidized boarding homes. One type is for temporary care of infants, in preparation for adoption or return to their parents. Similarly, interest has increased on the part of State divisions of child welfare in the use of available Federal funds for subsidized homes for temporary care of children, pending study or investigation.

Child-welfare agencies are trying more and more to select and hold trained foster parents, capable of working successfully with children whose behavior problems are more than ordinary ones. Such homes have been used in observing the behavior of children and making plans for them.

Another type of subsidized home is that developed as a residence club for adolescent girls or boys. Here, under supervision by an agency, trained foster parents work with adolescents who find it difficult to adjust in an average foster home or institution.

Recently, Federal funds for child-welfare services have been budgeted by States for subsidizing boarding homes that care for unmarried mothers and their children. It must be recognized, however, that such resources should be used, not as a substitute for Aid to Dependent Children, but only when care in a boarding home seems to be the plan most suited to the needs of the mother and child.

We can help a parent to help the child

Most important is the growing stress on providing service to the **parent,** as essential to providing service to the **child.** Agencies are departing from the concept that the job of the institutional worker or the foster placement worker is limited to contact with the child in his new place. This is one of the most encouraging developments in child-welfare thinking today, and possibly takes us a long step toward protecting for the child his right to establish permanent roots in a home of his own.

Two areas of need in foster-family care are especially urgent: Negro children, because of discriminatory programs, have not had adequate service. Also, in our rural population, large numbers of children have not yet been reached by State-wide public or voluntary services.

In the last few years the social aspects of adoption have received much attention. During that time

more than half the States have re-enacted or amended their adoption laws, and there has been a growing tendency to recognize the need for adequate legislation to protect not only the child, but the natural parents, and also the couple that plans to adopt the child.

But good adoption legislation is not enough. The most progressive statutes will be ineffective without the services and facilities necessary to carry out their purpose and intent. Legal protection for the child will not be genuine even though the law requires that every family petitioning to adopt a child be studied by a "recognized agency," unless that agency has the essential equipment for doing the job. This means strengthening staff as well as allowing more leeway for stronger administrative support of an important service. It also means that a well-equipped adoption agency will be as ineffective as one that is not well-equipped unless it can enter the picture early—not merely when an adoption is all but accomplished.

Nor can we overlook the importance of our "basic" services in connection with a more effective adoption program. If we stop and think about the essential connection between good adoption services and other standard social services, we see that their interdependence is likely to be overlooked. It is impossible to maintain a good adoption program when general public assistance, family service, Aid to Dependent Children, medical services, and placement services are inadequate.

It is estimated that for every child available for adoption there are at least 15 couples asking for a child. Private agencies cannot hope to provide all the services demanded by the great number of families applying for adoptive children; public agencies must assist. We **cannot** use the main part of our voluntary funds in order to provide the needed adoption services to the exclusion of other kinds of foster care.

Serious problems, however, can accompany development of public adoption services, not the least of which is the tendency to take up such specialized and skilled functions before other basic public child-placing services are functioning effectively. Many States, under pressure to provide adoption services, are strongly concerned lest such a move jeopardize a well-rounded program of social services for children, under public auspices.

A baby especially needs the individual care that is usually to be found only in a family home.

Many more agencies are charging fees to couples applying for children, so as to pay for at least part of this service. Fees range from a token payment of $15 to $500. One agency reports fees ranging up to $1,200 — the total cost. It must be conceded, however, that the use of fees by standard adoption agencies is in an experimental stage. Whether it succeeds will depend upon the quality of staff and the degree of acceptance by the community. The latter in turn depends on how clearly the agency explains the system.

Recently favorable and unfavorable publicity in regard to adoption has been renewed in the press and national magazines. This interest in adoptions can become mass hysteria concerning all social services provided by standard agencies; or it can be converted into real public education, if we are able and willing to use the opportunity. In the public mind adoption services bid fair to represent all organized social services for children, and child-welfare agencies therefore are directly challenged by public doubts.

When a mother works outside the home

One aspect of foster care which is rapidly taking a large place in the mosaic of community resources is the day-care center. In the past, day care was generally considered a somewhat unproductive pursuit of charity-minded ladies. More recently, however, despite the fact that community support has been slow, day care has been increasingly recognized. This is a logical outgrowth of the conviction on the part of placement agencies that a child should not be removed from his parents if there is strength in the family on which to build. This means that more and more agencies

(Continued on page 93)

AID TO DEPENDENT CHILDREN KEEPS HOMES TOGETHER

JANE M. HOEY

EVEN in prosperous times, many families with children have a hard time making ends meet, particularly since incomes tend to be lowest in homes where children are most numerous. Nevertheless, when father and mother pull together and when children share in the family job of penny-stretching, many a home can be healthy and happy on a surprisingly small income. Each treat is enjoyed all the more because it represents a triumph in the battle against poverty.

From generation to generation

But if the family's annual income is as low as $2,000, or less—and one out of five children in the United States lived in such families in 1950—the contest is often too grim to be fun. The bad housing and malnutrition that go along with low income often endanger health. Hope for a better future is dimmed by the dreary struggle for daily existence. When this happens, a family may sink into a Slough of Despond, and it may no longer seem important whether or not the children go to school and church regularly; or what traits of character they develop; or how or where they seek amusement. Under such conditions children frequently grow up to be social problems instead of wholesome, useful members of society. As adults, they, in turn, raise their children under unwholesome conditions, and the chain of trouble carries on from one generation to the next.

For years this problem has confronted social workers, teachers, nurses, church workers, and others concerned with the health and welfare of children. Frequently they have broken the vicious chain by giving the family or some member of it the encouragement and specialized help that make a better life possible. All too often, however, their efforts have been thwarted because the economic need was too overwhelming. The family needed the services these workers could give, but could make little use of them unless the fundamental needs of food, clothing, and shelter were also met.

Certain provisions of the Social Security Act, passed in 1935 and subsequently amended, aim to fulfill these fundamental needs. The social-insurance provisions and those dealing with public assistance authorize Federal aid for programs specifically designed to prevent the most extreme and abject poverty.

The social-insurance programs include (1) Old-Age and Survivors Insurance, which enables many workers to provide an income for themselves and their families when their earnings are cut off by old age or death, and (2) Unemployment Insurance, which provides income during periods of unemployment.

The public-assistance programs provide aid for some of the people who are not covered by social insurance and who are too old, or too young, or too disabled to earn a living for themselves. Originally the public-assistance provisions included three programs: Old-Age Assistance, Aid to Dependent Children, and Aid to the Blind. In 1950, through an amendment to the Social Security Act, a fourth program was added, Aid to the Permanently and Totally Disabled.

Stimulated by the availability of Federal aid, the States set up their own public-assistance programs, or adapted their existing programs to the Federal requirements, and defined the standard of living that would be maintained for needy people receiving assistance. Since each State had to put up matching funds in order to receive Federal aid, poor States could not afford to set their standards as high as rich States, and often had to be more stringent in defining what resources would render people ineligible for aid. Even though the programs were so different in the various States, a planned attack against poverty went forward throughout the country.

The small cash public-assistance payment many people—elderly men and women, blind and disabled individuals — receive regularly from their county or State public welfare office prevents their needing services that would be more costly. Likewise, children who might have become juvenile-court problems get parental supervision. Their mothers, managing on Aid to Dependent Children payments, need not go out to work.

For some people, however, this economic aid has not been enough. They are the ones who, because of mental or emotional handicaps,

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After receiving her M. A. degree from Columbia University, she was graduated from the New York School of Social Work.

Miss Hoey was President of the National Conference of Social Work, 1940–41. She is President of the William J. Kerby Foundation; is a Vice President of the National Social Welfare Assembly; a member of the National Council on Social Work Education; and a member of the Executive Committee, United Community Services, Washington, D. C.

Miss Hoey was alternate representative of the United States to the sixth session of the Social Commission of the Economic and Social Council of the United Nations. She also served as the United States representative to the seventh session of that Council, held in Geneva, Switzerland, in 1951.

need a variety of special services. Among these people are still found the problems that have long concerned workers in all aspects of the child welfare field — the children who are truants from school, the delinquent adolescents, the fathers who desert their families, the mothers who are slovenly housekeepers. Part of the economic problems in some such families are now being met through the Aid to Dependent Children program; but workers in this program, with heavy case loads and little professional training, have not been able to provide the multitude of services that might lift these families—or at least the children—onto a higher plane of living. Nor have services from other sources, for health, welfare, education, religion, recreation, and so forth, been able to fill the gap. A floor has been put under poverty—though in many areas it is a thin and shaky one—but measures to cope with related problems have not been stressed equally.

From one standpoint, it could be said that there is nothing new or alarming in this situation. There have never been sufficient services to meet the needs of all the maladjusted.

From another standpoint, however, we can see that the lag between efforts to meet economic need and efforts to meet social need has already produced serious consequences, for it has led to public misunderstanding about the Aid to Dependent Children program.

Because antisocial behavior is always more conspicuous than is conventional behavior, the public tends to identify all families who receive public aid with the few families whose needs are complicated by the fact that some member does not behave in a socially approved manner, such as the father who deserts his family, the mother who neglects her children, or the daughter who has a baby born out of wedlock. Some people, not recognizing the underlying causes of such behavior, believe that the public-assistance program contributes to it.

Under the impression that public assistance saps the moral character of those who receive it, some people think the problem can be solved by introducing restrictive measures. Such measures, aimed at punishing maladjusted adults, inevitably bring hardship to needy children. Equally serious, and of even more concern to professional workers in the child-welfare field, is the fact

FACTS ABOUT ADC

PURPOSE OF PROGRAM. To enable needy children to live in their own home and to receive care, affection, and supervision from a parent or close relative.

SIZE OF PROGRAM. 1.5 million children, or about 3 percent of all the children in the United States under 18 years of age are totally or partly dependent on Aid to Dependent Children.

COST OF PROGRAM. Out of the national income dollar less than three-tenths of a cent goes for Aid to Dependent Children payments. Total cost in 1951 was $568 million; this includes Federal, State, and local funds.

HOW FINANCED. The Federal Government will pay three-fourths of the first $12 paid, per person per month, plus half of the balance of all expenditures up to $27 for the mother or other caretaker, $27 for the first child, and $18 for each additional child. The remainder is paid from State funds or from combined State and local funds.

ELIGIBILITY. The program is limited to needy children whose wage-earning parent is dead, incapacitated, or absent from home. Each State establishes its own definition of need and sets its own terms about requiring families to exhaust other resources, including support from relatives, before becoming eligible for aid.

PERIOD WHEN AID CAN BE GIVEN. Children can be aided until they are 16, or 18 if still in school. However, the average length of time aid is needed is estimated to be less than 3 years.

RESULTS OF PROGRAM. Follow-up studies made in several communities show that most children aided in the early years of the program have developed into stable, tax-paying citizens. Where school-attendance records have been studied, it has been found that the attendance of children who have received assistance under the program for Aid to Dependent Children tends to be higher than that of the general school-age population.

HOW YOU CAN HELP. Study these facts and tell others about them. Learn more about the program in your own community from your local welfare office.

that, if the belief prevails that withdrawal of financial aid will solve social problems, ways of arriving at more basic solutions will continue to be neglected.

One way to approach these problems is to try to prevent them from developing. A tremendous step in this direction would be more low-cost housing and more slum clearance. Other helps would be more day-care centers for children of working mothers, more social case work for children in their own homes, more foster homes, and more child-guidance clinics. These and other facilities and services would help to salvage children now growing up in bad environments. But to deny to them aid in their own homes, however poor these homes may be, when better ways of aiding them are unavailable, adds to their deprivation and intensifies their problems.

Social services make aid go farther

If the people as a whole can gain a better understanding of public assistance they will realize more clearly that the programs protect only minimum living standards among the 3½ percent of our population receiving such assistance, and that this small help prevents much suffering. And better understanding of the nature of the problems that public-assistance programs are trying to meet will lead people to support more strongly the various public and private services that enhance economic aid.

We already see countless indications that underprivileged children are the victims of lack of public understanding. Several States are making plans to publish the names of all persons receiving assistance. Advocates of this procedure do not really want to expose sensitive children to the jibes of their classmates, but they think it is the only way to get rid of the many "chiselers" that they have been led to believe are receiving public aid.

Several special investigations, conducted by States and cities where a large amount of "chiseling" was suspected, have revealed that the total number of ineligibles receiving aid is less than 3 percent of the total. And some of these had become ineligible only through changes in State laws. The actual number of fraudulent cases turned out to be very small.

Moreover, publication of names has been tried in several State and locally financed programs and abandoned because it did not reduce the number of people receiving payments and it did increase administrative problems.

But these facts are not generally known. And the general public does not realize that the eligibility of each person receiving assistance must be rechecked at least once a year by the State government, as a condition for receiving Federal funds. Nor is it widely understood that full information about recipients has always been available to boards of public welfare, legislative bodies, and others responsible for insuring efficient administration of the programs. Because many people do not know these facts, thousands of children and their families may be humiliated by having their poverty made a matter of public gossip.

Children are being injured also by well-intentioned but extreme measures being taken in some places to force support from fathers who have deserted or abandoned them. In some places, children become ineligible for public aid if a court order for support has been entered against the father, whether or not the support is paid, and whether it is adequate or not. Sometimes an unemployable man with a long history of cruelty to his family is returned to the home, thus not only depriving the children of the benefits of the Aid to Dependent Children program, but also creating a home environment of fear and terror. In some cases, an alcoholic or otherwise unemployable father is jailed for nonsupport, and the whole sordid story is published in the local papers, to the great humiliation of the family and without any saving to the taxpaying public —in fact, at an extra cost for prison care.

The child born out of wedlock, handicapped to begin with by the circumstances of his birth, has been under particularly heavy attack in connection with Aid to Dependent Children, because many people have been led to believe that some women deliberately enter into unwed motherhood as a means of becoming eligible for public assistance. Proposals are being seriously made to deny assistance to unmarried mothers, to put all such children in institutions, and to jail the mothers. These indicate of course, how little the general public understands the problem of illegitimate birth.

Of all the steps toward undermining the public-assistance program, the one that affects the most children is the arbitrary reduction in the amount of assistance that has been made in some places. In one State, for example, no more than $50 a month can now be given to any one family, no matter how many children are in the family and no matter how great is their need. For the Nation as a whole, the average payment per person in the Aid to Dependent Children program is $21 a month. The goal of the program —to keep children at home with a parent or close relative and to make it possible for them to complete high school—is becoming increasingly unattainable as prices rise and the gap widens between what is needed and what is received.

If the public is to evaluate the strengths and weaknesses of this program and to find sound ways of meeting the unmet needs of the children the program is designed to serve, they will have to understand the program better. Everyone who works with children has a stake in telling the people in the community the truth about these programs and in preventing the spread of misinformation that leads to measures injurious to many children.

Facts about the Aid to Dependent Children program that all workers in fields concerned with children should know are given on page 87.

Reprints in about 6 weeks

CHILD-LABOR STANDARDS RAISED IN FIVE STATES; LOWERED IN EIGHT

BEATRICE McCONNELL

STATE LEGISLATURES meeting in 1951 enacted laws concerning child labor that reflect the pressure for manpower throughout the country. Although some advance occurred, a discouraging tendency toward relaxation of labor standards can be seen.

The legislatures of 44 States, Puerto Rico, Alaska, and Hawaii met in regular session in 1951. In a number of these States comprehensive child-labor bills, raising standards, were introduced, but none passed. On the other hand, acts lowering child-labor standards or authorizing relaxations of such standards were passed in eight States. Four of these acts—in Indiana, Ohio, Utah, and Wisconsin—are called emergency measures, and are limited to a definite period of time.

The Indiana and Ohio acts relax night-work standards for girls 16 and over. The Indiana act, effective until March 15, 1953, permits girls of 16 and 17 to work until 9 p.m. instead of 7 p.m. in all occupations except those determined by the State commissioner of labor to be hazardous. The Ohio act, effective until September 1, 1953, permits girls of 16 and 17 to work until 9 p.m. instead of 6 p.m., and suspends the prohibition of night work between 10 p.m. and 6 a.m. for girls 18 to 21.

In Utah the minimum age is lowered from 16 to 14 for employment outside school hours in the first processing of agricultural products, and, if so decided by the State commissioner of labor, in other nonhazardous industries. This act is effective until the end of the national emergency or February 15, 1953, whichever occurs first.

Under the Wisconsin act, the State industrial commission is authorized, during the period covered by the Selective Service Act of 1948 or other compulsory military-service law, to permit boys of 12 to engage in house-to-house street trades. The former minimum age for such work was 13 years.

Additional backward steps

The four other acts lowering standards set no expiration date. An amendment to the North Carolina child-labor law permits girls of 17 to work until 10:30 p.m. as ticket takers or cashiers in motion-picture theatres. Florida and Hawaii laws permit children of any age to work in making motion pictures, although in Hawaii this is limited to times when children are not legally required to attend school. Under all three of these acts, the State commissioner of labor is authorized to set conditions under which the minors may be employed.

An Alaska act suspends the 8-hour day and 40-hour week for minors 16 and 17 for work during school vacations, provided the work is in accordance with the prevailing wages and hours of the particular industry in which they are employed. The act also lowers from 18 to 16 the age at which a girl may be employed in a restaurant.

Along with these backward steps, a few advances were made, for amendments to the child-labor laws of five States raised standards to some extent. The Delaware child-labor law now requires that age certificates be obtained for minors of 16 and 17. The law formerly required that employment certificates be obtained for minors under 16, and age certificates were issued for minors of 16 and 17 only upon request. Now 22 States, the District of Columbia, Hawaii, and Puerto Rico require certificates for minors under 18 seeking employment, and one other State requires them for minors under 17.

In a New Hampshire act the 14-year minimum-age standard of the child-labor law was extended to include all occupations except agriculture and domestic service, instead of applying only to specified occupations. An amendment to the California workmen's compensation law provides that benefits under the act for minors injured while illegally employed should be

(Continued on page 94)

It is in order to protect children like this that the President's Commission on Migatory Labor recommended that all State child-labor laws be made fully applicable to agriculture

BEATRICE McCONNELL is Chief of the Division of Legislative Standards and State Services, of the Bureau of Labor Standards, Department of Labor. She is Vice Chairman of the Interdepartmental Committee on Children and Youth. Formerly she was Director of the Industrial Division of the Children's Bureau.

FOR THE CHILD AS AN INDIVIDUAL

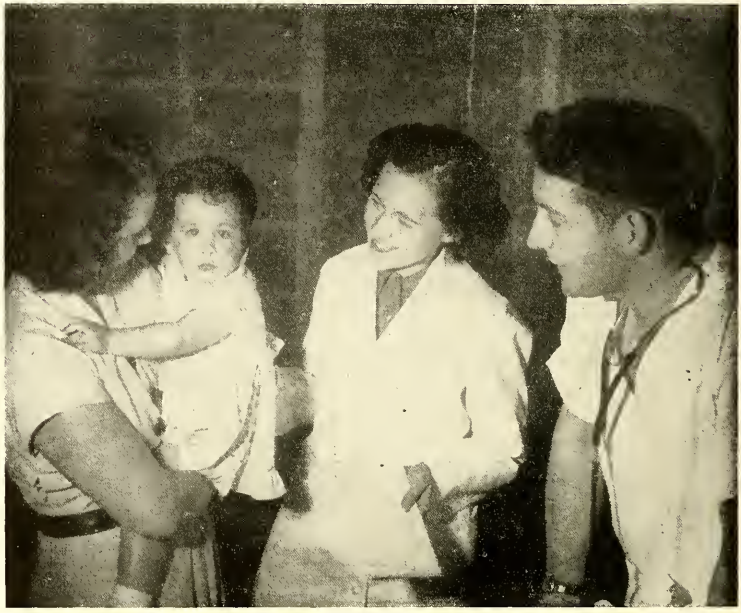
Case workers in health programs help to meet children's social and emotional needs

HELENE SENSENICH LIT

IN RECENT YEARS health agencies have been doing more and more to meet the needs of the individual. An example of early recognition of these needs is found in the efforts made by early child-health conferences and prenatal clinics to preserve the health of mother and child. A long step toward meeting the patient's individual needs was taken a decade and a half ago, when Federal-State programs for crippled children were established under the Social Security Act, aiming to provide complete medical care for children with crippling conditions. As time went on, and these programs were broadened to include not only the conditions that are known as orthopedic crippling, but also certain other conditions—rheumatic fever, cerebral palsy, epilepsy, and others, the trend toward individual care continued. And throughout the years, health agencies had become concerned with the individual needs of adults with tuberculosis, cancer, or heart disease. Creation of State mental-health program also indicates recognition of the patient's individual needs.

HELENE SENSENICH LIT, whose A.M. degree is from the University of Chicago's School of Social Service Administration, is a regional medical social consultant on the staff of the Children's Bureau. Before joining the Bureau, Mrs Lit was on the staff of the Washington State Department of Health. For some years before that she was a case worker in the Social Service Department of the Graduate Hospital of the University of Pennsylvania, Philadelphia.

This article is based on a paper given by Mrs. Lit at the seventy-eighth annual meeting of the National Conference of Social Work.



A clinic physician has asked the medical social worker to help a mother who is worried about the treatment he has recommended for her child. She will talk these worries over with the worker and will have her help in planning for treatment and in carrying it through.

Through what we have learned from many and various programs, we now see patients more clearly as persons, as human beings with social and emotional needs. We know that specific treatment for a twisted leg or a swollen joint is not enough. We realize how strongly a child's physical well-being is influenced by his feelings about his family, about his school life, and about his playmates.

As we recognize more and more how closely the individual's physical, social, and emotional needs are interrelated we can see better how necessary is teamwork between the members of various professions who are trying to help him to return to health. The doctor, the nurse, and the medical social worker are members of the team that helps many children. And often other workers play an important part on the team, such as the nutritionist, the physical therapist, the occupational therapist, and the speech therapist.

When the crippled children's services first went into effect, only a few case workers were employed in State health agencies. But these services, emphasizing individual medical care, brought out forcibly the need for attention to such children's social and emotional needs, and more and more medical social workers were brought into the programs. In the fiscal year 1951-52 practically every State health agency has medical social workers on its staff.

But even now such workers are

relatively few and the number of children who need their services is great. And so the amount of individual work with children is still limited. Besides, much emphasis has been placed by medical social workers on such important services as consultation with other professional staff, and participation in program planning and community planning. A great deal could be said about the valuable work that such workers do in these fields.

In order to make the best use of the time available for giving attention to individual children, efforts are made to provide case work at times when the need of the child and his parents is most acute. One of these times is when the child is brought into an itinerant or "field" clinic. It is here that an adolescent would-be football player is told that he needs to go to a hospital and be placed in a cast. It is here that a mother learns that her baby—a baby she did not want—has a congenital deformity; and she is terrified by the idea that the deformity is the result of her not taking good care of herself during pregnancy. It is here that a little girl who has been brought in just "feeling tired" suddenly faces a diagnosis of rheumatic fever, with the accompanying fears and the threat of separation from home.

All these situations, and a multitude of others, come to the attention of the medical social worker when a field clinic is being held. The children's need for help is immediate, and the workers must give the most help possible within the confines of the clinic, bearing in mind that the community may have no resources for continuing skilled case-work service.

Even though the worker may have no opportunity to continue her services after the clinic is over, she can still do much to help the child, for the impressions that she gains from her interviews with the child and his parents contribute greatly to the clinic's plans for helping the child. As part of the health team, she shares her impressions with the other members of the staff, so that the final plan for medical care will take into consideration the total needs of the child. And in order that his care may follow a continuing plan after he leaves the diagnostic clinic, the medical social worker also conveys her impressions to the staff of the hospital or other special facility where the child is to go for treatment.

To give help when it is needed most

If the State program has a very limited medical social staff, the worker tries to help the child through the most crucial periods of his treatment. And so she may give some service to children while they are in the hospital. This has been done most frequently in State-operated crippled children's hospitals or cerebral-palsy treatment centers. Occasionally a limited service is given to a child who is being treated in a hospital that has no social-service department. When giving this service the worker collaborates closely with members of the hospital staff and the local health department. In some treatment centers, where the State agency is able to allow the worker only 2 or 3 days' service a week, or sometimes less, the service she gives must, obviously, be limited.

The service given by a medical social worker to children in a hospital includes, for example, the help she can give to Bobby, who had expected to graduate from school this year at the head of his class. But on account of the length and severity of his illness he will not be able to graduate at all until some future time. Then there is 15-year-old Jessie, who is about to leave the hospital after recovering from severe burns, but who can't bear to go home because not all the scars on her face have disappeared. The worker learns from the girl that part of her trouble is that she feels that she can no longer compete with her attractive sister. It is easy to see how much this child needs help.

Case-work service given by staff of State health agencies, limited though it is, has done much to bring to the fore the effect of social and emotional factors on children's health. It has demonstrated, on an individual basis, the need for considering what there is in Johnny's

The medical social worker is introduced to Mary and her mother by a public-health nurse, who has found that they need case-work help in adjusting to a long period of care at home.

family relationships, and in Johnny himself, that will have to be taken into account before the treatment he receives can be truly helpful to him. As a result of this, and as a result, too, of the increased awareness in public health of the patient as a person, many of the medical social services that were originally centered in crippled children's programs are provided also in maternal and child-health and other public-health programs.

Local health departments employ case workers

Similarly, increases in development of medical social services have taken place in county and city health departments. In some places State medical social workers had been giving services at diagnostic clinics, and local staff members had become interested in having this type of service available in their own department. In others, through consultation with medical social workers, health officers and their staffs had become increasingly aware of the contribution that medical social work could make to public health, and as a result local health departments have established medical social positions.

The county or city health department represents a rapidly developing field for the practice of medical social work. As a rule, the medical social worker offers case-work service on a "generalized" basis. She is not limited to one program or one diagnostic group, such as crippled children's services, or tuberculosis control, but carries responsibility for service in a variety of health department programs. Of course the number of these programs varies considerably from one department to another, but they may include maternal and child health, hearing, and speech; as well as syphilis, tuberculosis, cerebral palsy, rheumatic fever, and so forth. The greatest limiting factor is the worker's time and strength.

In order that the worker's services may be used with the best results, it is necessary to be selective in giving help where it is needed most. Priority, of course, should go to patients whose illnesses or the treatments recommended are most likely to bring about social and emotional tensions in the patient himself or in his family.

For example, a child with cerebral palsy and his parents would be especially in need of service—the child's parents, to help them to accept the child and his disability; and the child, to help him learn to accept himself; and both child and parents, to help them to face the long period of training that will be necessary. Again, an adult facing a diagnosis of tuberculosis, requiring him to enter a sanatorium, should certainly have help in planning for long-time care away from his home and family.

Since long-time care is hard to carry out, a family may have a rough time unless they receive help; and if the plan seems too difficult it may not be carried out at all. In order that this may not happen, it is urgent that something be known of the patient and his family at the time the plan is evolved, so that consideration may be given to their special needs.

To meet this situation the medical social worker gains information about the family, its strength, and its needs, on which a kind of social diagnosis can be based. She carries responsibility for determining the social and emotional factors that surround the illness and affect the ability of the patient and his family to carry through the plan for medical care.

In the course of her study of the patient and his family, the medical social worker is able to give them some help; but, what is also important, she contributes her knowledge of their social needs to the other members of the health team, so that the team can take these into account when planning for the care of the patient and when carrying out that plan. The medical social worker may continue to offer intensive case-work help to the patient, if this proves to be necessary.

In many cases the medical social worker will recognize needs in a family situation that can be met only through collaboration with workers outside the health agency. Here she will use her knowledge of community resources in order to help the family.

For example, she may see a child who, after he has completed hospital treatment, will need to continue under close medical supervision for several months. But his home is in a community far from the center. In such a case the medical social worker may plan with a child-welfare worker, who would make it possible for the child to stay in a foster home as long as necessary, and would help him in his adjustment to it.

Again, the medical social worker may be asked to help a mother who is about to go to a hospital for an operation, and there is no one to care for her children at home in the daytime. In this case, the medical social worker may plan with a social agency for the services of a homemaker, who will help keep the family together until the mother can again do her housework.

According to the individual's needs, the medical social worker may need to plan with many types of agencies, such as a child-guidance clinic, a vocational-rehabilitation agency, and a welfare agency that will provide financial or general case-work assistance.

In situations needing these various types of help, the medical social worker helps the family to understand and accept the services of the other agencies, and continues helping the family in relation to its health problems as a part of the total plan for meeting their special needs.

Case-work service may forestall trouble

In addition to these services, we find that increasing emphasis is being placed on what we have rather haphazardly called "preventive" case work. I am not sure that the term is valid, or even really descriptive of what we mean; it is somewhat casually borrowed from the idea of preventive medicine. It has been applied to some of the case-work services offered in both

child-health and prenatal clinics.

An example of this type of work: Here is 3-year-old Davy. He shows no evidence of illness, nor of any outright "behavior problem." But his mother handles him with great tenseness; she mentions his restlessness, his poor eating, and his poor sleeping. The case worker recognizes that he may very well be reflecting his mother's tensions. And it is no surprise to the worker when the mother tells her about marital troubles, or her parents' desire to "take over." The service offered the mother is social case work; and help may be needed on a short-term basis, or a long-time and intensive basis. Its so-called "preventiveness" rests on the fact that as yet this social or emotional stress has not been reflected in illness, nor has the stress become so acute as to cause the mother to seek help from a community social agency.

This whole area of medical social service has been expanding in recent years and will probably continue to do so as the World Health Organization's definition of health as a state of complete mental and social well-being, as well as physical, continues to gain interest and acceptance. It is impossible, however, to predict the future, or to speak with assurance about what the trends of today may mean in terms of medical social work practice tomorrow. Some of the developments that we have noted, however, give evidence of an increasing awareness of those particular social and emotional needs that can best be met through the specialized service of a case worker.

The world is becoming increasingly interested in the health of the child, and in all the factors that might influence the maintenance of his health or affect his medical care. With the broader definition of health, these factors are of interest to health agencies. Certainly, with this concern for the needs of the individual, it is not surprising that the demand for medical social workers exceeds the supply.

Reprints in about 6 weeks

AWAY FROM HOME

(Continued from page 85)

need day care as a supplementary service, a means of strengthening the family unit.

Placement agencies are showing interest in day care given in foster-family homes, which suggests that this type of daytime care may become a permanent part of child-caring services in communities.

Much of the need for day care stems from the fact that more women are equipped to work outside the home. In many communities, however, facilities are entirely inadequate to care for children when mothers must be providers. State funds are available for day care in only two States, and municipal funds in a few large cities.

We must inform the public

An important aspect of day care has to do with adequate licensing. Many nurseries recognize that absence of legal safeguards is a serious threat to their programs. In day care, as in other child-welfare programs, when harmful, substandard programs exist, adequate programs will suffer through comparisons as to cost, hours, and so forth.

I have mentioned some of the major developments in certain areas of foster care. I am conscious of omissions. I might have mentioned, for example, the housing of children in jails while waiting for a court decision on their placement. One can only be shocked at our failure to provide adequate foster care for such children, and equally shocked that preventive and protective measures are so inadequate as to permit ever-increasing numbers of children to come to the attention of the courts. There are other critical gaps that are scarcely being touched.

The final stress to be made here is that better methods, improved understanding, willingness to change, more effective planning, will avail nothing if we are unwilling to face realistically the distinct problem related to all of these trends. I refer to the need to tell the public at large honestly and fully what is involved in a good child-care program in any community and what it costs.

We all know that more of both voluntary and public funds are necessary for an adequate child-care program. We agree also that the public has a right to know how much of a job its funds are accomplishing; how much more needs to be done; and how much it will cost. Indeed, our present inadequate methods of explaining how these funds are used have placed the public unwittingly in the role of accepting and condoning poor service in many areas.

Confusion is also encouraged through failure to make clear that in many instances public funds are subsidizing large portions of agency budgets. A private child-placing agency receiving large amounts of public funds on a broad subsidy basis cannot be an independent and free agency in setting and carrying out its policies. Strong public and strong private child-care agencies are essential in our society, and we have a responsibility to inform the public as to the requirements of coverage and financing of both. Both have joint responsibility for community planning to meet the child-care needs in any community or State, and for working out together their cooperative functions, community by community and State by State. Until this is done, progress in child-care services is in jeopardy.

Not new at all is the need to tell the community what a good program costs and what are the responsibilities of public and of private agencies. We have faced this need in different ways at different times —often, as now, half-heartedly or incompletely. We must change this. We must face facts in an atmosphere of complete mutual respect, unhampered by our special interests or set ideas. And we must face them with our eyes clearly on the welfare of children.

Reprints in about 6 weeks

CHILD LABOR

(Continued from page 89)

increased by 50 percent. This makes 17 States and Puerto Rico that provide additional compensation for such minors.

A temporary improvement has been made in Ohio. In the emergency act providing for temporary relaxation of the provisions concerning maximum working hours for girls, there is included also an 18-year minimum-age requirement, applicable to a considerable number of hazardous occupations. This requirement, however, is effective only for the period of the act— until September 1, 1953. In Illinois penalties are materially increased for employment of children under 14 in certain types of public entertainment.

School-attendance requirements, which are closely related to the regulation of employment of children, were also strengthened in a few States. An amendment to the Illinois law eliminates the conflict between the compulsory-attendance provisions and a 1947 amendment to the child-labor laws. The minimum school term in South Dakota is extended from 8 to 9 months. In Wisconsin the former exemption from school attendance for children living more than two and a half miles from a school was deleted.

Although the final enactments for 1951 were not entirely adverse, it is clear that present and impending pressures to obtain more workers threaten to undermine hard-won gains made in former years. Child-labor and school-attendance standards serve as a guide in preventing harmful employment of boys and girls. They protect youth from the consequences of their own inexperience. If employers, schools, parents, unions, and the community as a whole join in supporting full maintenance of child-labor and school-attendance laws during the present emergency, this cooperative action will aid in conserving and building up the capacities of boys and girls for their future responsibilities.

IN THE NEWS

Birth registration. The chances are 98 out of 100 that today's baby will have a birth certificate, according to preliminary results of a Nation-wide test. The test, the second of its kind in our history, was conducted by the Public Health Service of the Federal Security Agency, and State health departments, in cooperation with the Bureau of the Census, Department of Commerce.

In this birth-registration test, the April 1950 census records of 800,000 babies born during the first 3 months of 1950 were matched against the birth-registration records.

In 1940, when the first national survey was made, it was found that 92.5 percent of newborn babies were registered, compared with 97.8 in 1950. For every hundred babies born in 1940, 7 were not registered. In 1950 only 2 in a hundred were not registered. Much of the gain is due to greatly improved registration among nonwhite groups. Only 7 in every hundred nonwhite infants were unregistered in 1950, compared with 18 per hundred in 1940.

State and local registrars are already studying the results on a county-by-county basis. Most States with problem areas have indicated that they intend to find out the specific reasons that birth certificates were not filed, so that promotional campaigns may be tailored to fit the conditions responsible.

The Children's Bureau in 1914 published as its second bulletin, "Birth Registration; an aid in protecting the lives and rights of children." In 1915 the Bureau of the Census established the Birth-Registration Area including 10 States and the District of Columbia. Year by year State health agencies and citizens' organizations worked for State birth-registration laws until in 1933 all the States were included in the birth-registration area. The 1950 test shows that the doctors, midwives, and hospitals that file birth certificates and the registrars of vital statistics that record them have now achieved substantially complete birth registration in the United States.

Married women employed. More married women were working in 1951 than ever before in the Nation's history, according to advance data from a sample survey by the Bureau of the Census, Department of Commerce, released December 26, 1951. In April 1951 more than 10 million married women were in the labor force (employed or looking for work). This is about 1 million more than in March 1950 and about 1½ million more than in April 1949. No figures are yet available on how many of these women have children.

Korea. Clothing for at least 240,000 Korean children is in prospect, with the arrival in Korea of two shipments of cotton cloth, more than 2,400,000 yards, from the United Nations International Children's Emergency Fund (UNICEF).

The cloth is being allocated by the Central Relief Committee, including representatives of the Government of the Republic of Korea and the United Nations Civil Assistance Command. Distribution is to be made to orphans and refugee children in institutions and in needy families.

Children-to-children. Articles of clothing sent as gifts by American children to India as a gesture of friendship have been distributed to children in Delhi at a ceremony arranged by "Balkan-ji-bari" (a nation-wide children's organization). Balkan-ji-bari will reciprocate by sending good-will tokens to American children.

Scholarships. If you know some one who would like to be a worker in some field concerning children but who cannot afford to pay tuition in a school of, say, social work or nursing, why not look into the possibility of a scholarship? The Office of Education, Federal Security Agency, has recently published a bulletin that gives information on financial aids for undergraduate and graduate study. The bulletin is titled, "Scholarships and Fellowships available at Institutions of Higher Education." (Bulletin 1951, No. 16. 248 pp. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. 55 cents.)

To Our Readers—

We welcome comments and suggestions about **The Child.**

• FOR YOUR BOOKSHELF

THEY WORK WHILE YOU PLAY; a study of teen-age boys and girls employed in amusement industries. U. S. Department of Labor, Bureau of Labor Standards, Bulletin No. 124. Washington, 1950. 26 pp. For sale at Superintendent of Documents, Government Printing Office, Washington 25, D. C. at 15 cents. 25 percent discount on orders of 100 or more. Single copies free at Bureau of Labor Standards.

Nearly 200,000 young workers under 18 — nearly 80,000 under 16 — are employed in various industries furnishing public amusement. This little bulletin gives facts concerning the extent and type of young workers' employment, their working conditions, and a summary of State child-labor standards and their administration.

Although important advances have been made during recent years in protective State legislation for young workers, youngsters employed in the recreational service industries have not shared to the same extent as other young workers in the benefits. Their work is largely part-time employment, carried on in the traditional leisure-time hours of the general public — late afternoon, evening, and on Saturday and Sunday. And because of the local nature of their employment, few children who work in amusement industries are covered by Federal child-labor legislation.

GOOD SCHOOLS DON'T JUST HAPPEN; a guide to action for life-adjustment education. One of a series of Better Living Booklets. Science Research Associates, Inc., 57 West Grand Avenue, Chicago 10, Ill., 1951. 26 pp. Single copies 10 cents; 100 or more 5½ cents each.

Life Adjustment Education is a strong movement to adapt public education to the needs and opportunities of all youth in our changing world. It is fostered jointly by the Commission on Life Adjustment Education for Youth, and the Office of Education, Federal Security Agency. This booklet, which was prepared by a lay advisory committee working with Office of Education staff, is for the use of interested community leaders.

Part 1 points out changes that have made the entire community the laboratory of modern education. It provides a simple scoring technique for evaluating the extent of community acceptance of the goals of a good school, such as helping youth to acquire the basic tools of learning; to select activities that prepare them for life; to prepare for, get, and hold a job; to maintain mental health and physical fitness; to budget, save, and invest wisely; to do what is right; to be a good citizen; and to be a good family member.

Some of the problems that must be solved by the school and the community are taken up in part 2 of the booklet. It lists questions designed to bring out the facts about each school and community.

Part 3 suggests what community leaders can do to help meet the life-adjustment needs of youth in their own communities.

References for further reading are included.

Edith Rockwood

• CALENDAR

Mar. 2–8. Save Your Vision Week. Information from Department of Public Information, American Optometric Association, Jenkins Building, Pittsburgh 22, Pa.

Mar. 3. Child Study Association of America. Annual conference. New York, N. Y.

Mar. 3–5. National Cancer Conference. Second national conference, Cincinnati, Ohio. Sponsored by the American Cancer Society and the National Cancer Institute, Public Health Service, Federal Security Agency.

Mar. 5–7. National Conference of Superintendents of Training Schools and Reformatories. Twenty-ninth annual conference. New York, N. Y.

Mar. 13–14. National Health Council. Thirty-second annual meeting. New York, N. Y.

Mar. 16–22. Camp Fire Girls National Birthday Week. Information from Camp Fire Girls, Inc., 16 East Forty-eighth Street, New York 17, N. Y.

Mar. 17–20. United States-Mexico Border Public Health Association. Tenth annual meeting. Monterrey, Nuevo Leon, Mexico.

Mar. 19–21. National Society for the Prevention of Blindness. Annual conference. Pittsburgh, Pa.

Mar. 29–30. American Psychosomatic Society. Ninth annual meeting. Chicago, Ill.

Mar. 31–Apr. 3. Council of Guidance and Personnel Associations. Annual meeting. Los Angeles, Calif.

Mar. 31–Apr. 3. National Vocational Guidance Association. Annual convention. Los Angeles, Calif.

Mar. 31–Apr. 4. Fifth American Congress on Obstetrics and Gynecology. Cincinnati, Ohio. Sponsored by the American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Ill.

Mar. 31–Apr. 6. National Boys' Club Week. Information from Boys' Club of America, 381 Fourth Avenue, New York 16, N. Y.

Area conferences, National Child Welfare Division, American Legion:

Mar. 6–8, 1952. Area C.—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Little Rock, Ark.

Mar. 14–15, 1952. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Portland, Me.

Regional conferences, American Public Welfare Association:

Mar. 6–8. Southwest region. Dallas, Tex.

Apr. 6–8. Central Region. St. Louis, Mo.

Aug. 20–22. Mountain region. Cheyenne, Wyo.

Sept. 2–4. West Coast region. Victoria, B. C., Canada.

Oct. 9–11. Northeast region. Philadelphia, Pa.

Regional conferences, Child Welfare League of America:

Mar. 13–15. Southern Regional Conference. Raleigh, N. C.

Mar. 31–Apr. 2. Central Regional Conference. Detroit, Mich.

Illustrations:

Cover, Philip Bonn for Children's Bureau.

P. 82, General Services Administration (formerly Federal Works Agency).

P. 85, George Jones for Children's Bureau.

P. 89, Library of Congress photograph.

Pp. 90 and 91, Children's Hospital, Washington, D. C.

THE CHILD

VOL. 16 NO. 6

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Helene Sensenich Lit

Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

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U.S. GOVERNMENT PRINTING OFFICE: 1952—952606

THE CHILD

MARCH
1952

BOYS AND BOOKS GET TOGETHER

Kansas Boys Industrial School uses books in its treatment program

LEITA P. CRAIG

The Boys Industrial School, at Topeka, Kans., operates under the State Board of Social Welfare. This school, which treats boys committed to it by juvenile courts, has in the past 5 years become one of the most outstanding treatment schools for delinquent children in this country. The institution has unusually well-developed clinical and educational services and makes excellent use of community resources.

"BUT BOYS like these wouldn't know what to do with books. They don't read the books the school has now. And they'd only deface new ones." This is what some members of the staff of our industrial school were saying a few years ago, when others of us were trying to get a library established in the school.

"Boys like these," however, are primarily human beings. They have the same needs as other boys, even if they do have some special needs also. It is true that they have been in trouble in their home communities, and that a juvenile court has committed them to a special school. But the purpose of our school is not to segregate a boy and punish him, but to give him special help in solving the problems that led to his trouble. And we who were pushing the library idea felt that a boy who gets opportunities to read and enjoy books might also find some help in them that would contribute toward solving his problems.

By "help" we did not mean moral lessons spelled out as such, but something more or less intangible, something that we couldn't quite explain. Perhaps we felt that part of the help the boys might get would be in the direction of restoring their self-esteem, which had been so badly damaged by their experiences.

We knew of the many fine books that are fun to read and at the same time suggest high standards of conduct — books that place service above self, and demonstrate the value of good citizenship and good family life.

Some of us realized, perhaps vaguely, that the boys would find some respite from thinking about their present trouble through interest in the great world that they would discover through reading.

And we knew that reading would open new windows to these boys, who had mostly very narrow, disadvantaged lives, and would broaden their knowledge and their interests. We did not plan to encourage the boys to be bookworms, but rather to gain a taste of the richness of life.

We who were urging books as a form of treatment won our point, and as soon as we could form a book committee, we set out to place some books in each of the four cottages where the boys live. Later, we were to establish a central library in the main school building.

The undertaking was a cooperative one; teachers, houseparents, and other staff members took part, as well as some outside friends who gave us not only books and money, but their time. We appreciated greatly the invaluable help we received from the book consultant for the Kansas State Teachers Association. And, best of all, the boys themselves joined in with suggestions.

We start virtually from scratch

Even before we began our drive for bringing books into our treatment program, we had taken stock of the books already in the cottages. It was true, as some staff members had said, that the boys rarely touched a book from the school shelves. And no wonder! For those dreary books in no way matched the needs and interests of the boys, nor their reading levels. The fine print alone would repel almost anyone, and books without

Listening to a recorded story is likely to lead a boy to get the book and read it for himself.

pictures simply don't attract youngsters.

So we discarded most of the books, and put bright jackets on the few we kept. The shelves were now somewhat bare. But we believed, correctly, that when we got new books they would attract possible readers more if they were not buried among books that the boys had already rejected.

The next step was to consult the boys about the kinds of books they wanted. The universal answer was "Dog stories and horse stories," with mystery tales a close third. No one mentioned comic books, but we guessed that this was only because the boys expected that we would frown upon these. And so we made a special point of buying some comics; of course we examined them carefully before buying. Later, the boys asked for wild-animal stories, adventure books, stories of knights, sports, railroads, and similar masculine subjects. A few boys demanded "stories from real life," and so we selected biographies written for boys of different ages.

Boys take the book program seriously

In each of the cottages we set up a reading room, refurnished it so that it now looks cheerful and attractive, and installed a basic collection of books for the boys to live with. In addition to these basic books four collections of 75 to 100 books each were planned to rotate among the cottages, so as to bring more books to more boys. Incidentally, about 2 years later, when the central library was functioning, our staff committee thought that the rotating was no longer needed, and that the rotating books in each cottage might as well become the property of the cottages. At that point, however, the advisory council representing the boys told us that they did not agree with us that the rotating of books should be abandoned. The issue is still pending, and we believe that the strong position taken by the boys' representatives shows how seriously they are taking the book program.

In the cottage dormitories boys tuck away favorite stories for prebedtime reading. And houseparents find that they are able to prevent some roughhouse at bedtime by reading stories aloud.

Some of the boys may never become readers, but many can enjoy a "read-aloud time."

About a year after the reading rooms were set up in the cottages we were able to establish the central library.

When a new boy is taken to visit the library as part of his orientation, he may be surprised to see a colorful, inviting room, with a carpeted floor, comfortable chairs, reading lights, and gay drapes. He is likely to find the librarian surrounded by several boys, enjoying a read-aloud time. Or, over in a corner, he may see one boy reading to another. Always there are several boys listening to story records. It is not unusual to see a boy stretched out on the floor, reading, as boys often do at home.

The books are arranged by subject, so that it is easy for a boy to find what he wants. He might not look through a whole section to find a dog story, for example, but he will go right to the shelf labeled "Dog Stories," and choose one.

Our books cover a wide range

Since the mentality of the boys ranges from very low to fairly high, books have been selected so that every boy may find something to please him. There are picture books intended for boys who are unable to learn to read, and there are books suited for boys of all reading levels, including senior high school.

When I say that we have picture books for youngsters who can't learn to read, this doesn't mean that the brighter boys don't like picture books; they do. And they keep up with the comics. And nearly all the boys enjoy listening to somebody reading aloud, whether on a record or face to face. Listening to reading aloud has opened a new world to many.

On one occasion Bobby, who is feeble-minded, demanded and obtained the opportunity for a special interview with his social case worker. As she sat with him, waiting

LEITA PHILLIPI CRAIG is Coordinator of Clinical Services at the Boys Industrial School, Topeka, Kans. Mrs. Craig came to the school 6 years ago as educational diagnostician, after becoming interested in children with special needs at the Kansas Receiving Home for Children. Before that, her experience was as a classroom teacher, principal, and visiting teacher, in the public schools of Atchison, Kans. Mrs. Craig's graduate work was done in clinical psychology at the Ohio State University.

to hear his problem, Bobby pulled a book out of his shirt and asked her to read to him. Since then he has had a weekly appointment with the worker, at which she reads to him from a book that he chooses.

Once the librarian noticed 10-year-old Jimmy, a colored youngster, examining the books. She knew he could read; but apparently he couldn't find any book that he wanted. She talked with him about various types of books, and offered him horse stories, dog stories, and others; but he refused them all. Finally he looked up at her, smiled shyly, and said: "I would like stories about little colored b o y s." Unfortunately, no such books were then at hand, but the library committee soon was able to place some on the shelves. After that Jimmy became a regular book borrower. And a few weeks after his first conversation with the librarian he confided to her, "I like books; they are my friends."

We find, every now and then, that a boy with a personal problem is helped by reading a story of someone with a similar problem, who is able to face it and work out a solution. George, for example, who was worried because he thought he was too fat, discovered in the library a story of a boy who could never do anything really well because he was fat and clumsy. The story of how the boy in the book faced this problem and "came through" helped George, just as it helps any of us with problems to know that we are not unique.

Come to the fair!

For the past 4 years the boys have invited parents and friends to an annual book festival, which lasts 3 days. The festival centers around an exhibit of the latest good literature for children and young people, which is brought to the school by the book consultant for the State teachers' association. Social events, such as a watermelon feed, add more fun. Last summer the kickoff for the festival was an old-fashioned outdoor ice-cream social—complete with home-baked cakes and, of course, a drenching rain.

As **The Child** goes to press, we are holding our fourth annual book mestival, scheduled for last summer, but postponed on account of flood conditions.

Committees of boys help to make plans for the festival and to carry them out. They unpack the books and help arrange the exhibit. And many a boy has found his most profitable introduction to books while he was helping prepare an exhibit.

During the festival the boys, besides acting as hosts, browse among the new books and listen to stories read aloud. They see original drawings that have been used in book illustrations. They examine dummies showing steps in publishing. They hear new story records. All this leads to a lot of book talk and book fun.

Hobbies encouraged

At one festival the exhibit focused on hobby books; and two teen-age boys from a neighboring town gave a magic show. Another year biography was featured, along with sports; and Glenn Cunningham, the famous mile runner, whose life story had been read by many of the boys, came to the festival.

As another step in linking books with real people, we encourage the boys in writing to their favorite authors. Many authors send the boys their photographs, and some send autographed books as well. A special corner of the school library has been set aside for these treasures. Eight authors have visited the school in connection with the book festivals.

The teachers have been the key persons in leading the boys toward wanting to read. Most of us know from our own experience how a teacher can arouse a pupil's interest in a book by telling incidents from it, showing pictures connected with it, and reading a chapter aloud. Our teachers arouse the boys' interest in books about people and places connected with their studies. They initiate book games and riddles, and they join the boys in putting up posters and other display material concerning books.

The book committee is constantly on the alert for material that is on a low reading level but is of high interest value. Thus we have a special collection of books that are attractive to some of our teen-age boys whose ability to read is that of most boys in the third or fourth school grade.

Another special collection includes books to entertain boys who are ill in the school infirmary or the city hospital. A social worker, or a houseparent, or a teacher takes some books to the patient — picture books, pop-ups, and quiz books, as well as riddles, games, and "things to do." And the staff member usually joins in the fun.

When it is necessary to place an extremely hostile boy in seclusion, for his own and others' safety, one of the staff visits the boy in the security room and asks him what materials he would like to have. Sometimes the boy asks for drawing materials, but more often he asks for books. And we are not afraid to lend even the choicest books.

More and more frequently the clinical staff is able to make recommendations for books to meet a specific boy's needs. Robert, a very depressed boy, enjoyed his orientation periods in the school library very much. The library was the one thing about the school that suited him! At the clinical staff conference for Robert the psychiatrist recommended that Robert should read books about other people who had suffered.

When selecting books for the library, our committee has learned to keep in mind some factors that experience has pointed out to us.

Book must be suited to boy

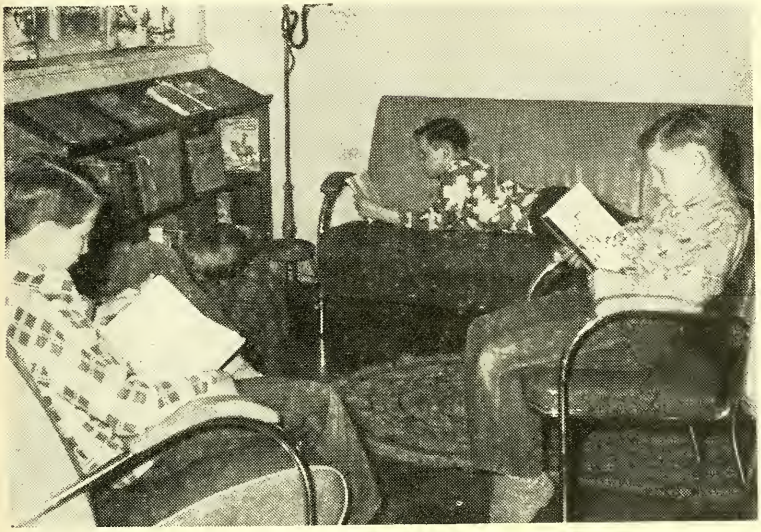
First of all, we try to select a book not only because it is good in itself, but also because it is suited to the intelligence, the reading level, the interests, and the needs of some of our boys. Since we usually have about 150 boys in the school, and the ages range from 8 to 18, we need a wide variety of books.

As a rule the books must be short. Our boys usually have a small at-

tention span and a strong underlying anxiety, and they simply cannot wade through a long book. And to hold their attention a book must be attractive, with clear print and good illustrations.

As their interests widen

Again, we try to place books in the library that reach not only the interests that the boys have now, but also books that they will want as their world enlarges. In other words, we take a boy by the hand and lead him as far as possible up



Boys and books seem to hit it off together in the library of the state school for delinquents.

the road to more and more desirable reading interests.

Very important — we let the boys do a great deal of selecting, themselves. We keep a "suggestion book" open on the librarian's desk and encourage the boys to write their suggestions in it. We post book lists so that any boy can look for book titles that attract him. And the annual book festival gives us all a chance to know about the latest books.

We feel that if books are to fulfill their part in our treatment plan, we must not set up any artificial barriers between the books and the boys. Getting the boys and the books together calls for open bookshelves, informal and usable arrangement of books, and a minimum of red tape in borrowing them.

Then, the book program must be a continuing one, constantly up to date. It needs to have a definite place in the school budget and new books should be bought regularly. This in itself is stimulating. And fulfilling the boys' requests for books is tremendously important, not only in giving each one the opportunity to read the books he feels a need for, but in giving him the feeling that we recognize his choice as important.

As for the stories in the books, the boys have shown us clearly what they want.

Action, action, and more action

Most of them want to read about aggressive characters. Psychiatrists tell us that this is because the boys feel so much underlying aggression and because they can identify themselves with these characters and thus gain some relief from their own feelings.

They like to read about danger. Their volcanoes must be erupting; their animals fighting.

We find that stories about poor boys who made good are popular. Maybe our boys see a ray of hope for themselves in these successes.

Certain boys want stories so far removed from any life they know that they cannot possibly identify themselves with the characters. Some of the most disturbed boys feel this way. They don't want to read about present-day characters; instead, they devote themselves to stories of the Middle Ages, "when knights were bold." However, some of the boys who like this kind of story have other reasons. One youngster, telling us about one of these stories, said of a character named Philip: "I like to read about Philip because he was a toughie before he became a knight." Then he added, "I wish it had told more about him when he was a toughie."

The call of the West is very strong. All the boys enjoy Westerns. Perhaps they need these as vicarious outlets for their energies.

Stories of pet animals are well liked, probably because they substitute for the joy of actually having pets.

And writing, too

As a result of their interest in books some of the youngsters have been writing stories. One 12-year-old, Charles, wrote a story, "The Little Black Chick," which was really the story of his life and had psychiatric significance. His friend James illustrated it, and they typed the manuscript and bound it. One class has been formed of boys who are writing for the school paper. Through this project, several staff members have become interested in writing and have joined adult writing groups in the city.

Reading has led to interest in plays, art, and music. When a local junior high school put on "Tom Sawyer," many of our boys went, in our school bus, to see it. Our art classes make book posters and illustrations. We notice that when a story record includes music the boys like it especially, and so we are planning to buy music records.

The librarian tells us that an average of 50 books are checked out

(Continued on page 109)

STATES IMPROVE MCH AND CC PROGRAMS

MARTHA M. ELIOT, M.D.
Chief, Children's Bureau

SIXTEEN YEARS have passed since Congress enacted the Social Security Act, establishing the responsibility of the Federal Government to help States and communities extend and improve their maternal and child-welfare services. In that period these programs have reached a stage of maturity that can give us all encouragement. There has been steady advance in the use of local, State, and Federal resources to establish new types of maternal and child-health and crippled children's programs. Funds have been used to extend existing services, to evaluate going programs, and to study new methods of organization to the end that new knowledge of medical care may be translated into action and more children in the smaller communities reached.

We could do better

To save more babies we shall have to work on many fronts. The health officer and his staff of nurses and sanitarians will need the help of such special workers as health-education specialists, medical social workers and child-welfare workers, teachers, economists, and social scientists.

Then there are the problems of premature births and fetal deaths. Many State health departments are providing special training for nurses and doctors in the care of prematurely born infants. They are setting up special premature units in hospitals and financing the medical and nursing care of "preemies." But causes of death associated with premature birth are still responsible for a third of the deaths occurring in the first year of life.

A pilot study of the mortality of premature infants under different types of care is now going on in Maryland. Research is also being carried out jointly by the Departments of Pediatrics and Obstetrics of the University of Colorado Medical School in this field. Much more research is needed if we are to get at the causes of premature birth and fetal death and therefore to be better able to prevent them. We already know from studies that mothers who have good diets during pregnancy have fewer premature deliveries than mothers who have poor diets. But without waiting for the new facts that research will bring forth, more and better prenatal care should be given to mothers, and special attention be given to adequate nutrition.

It is good to know that in 1950 only 7 mothers died in childbirth for every 10,000 live births, compared with 58 in 1939. But mere survival is not all that we want for mothers. Every mother should come through her maternity experience with abounding health, both physical and emotional.

The great reduction, since the last war, in the number of days that mothers stay in hospitals raises some new problems. What happens to mothers who go back to their housework 3 or 4 days after delivery? This is something that needs study. Should we not examine our maternity facilities and see if they are as simple and flexible as is compatible with maternity care of high quality?

Much needs to be done, too, to improve standards of care in maternity and children's hospitals. Hospital practices contribute positively to the mother's and the child's emotional as well as physical health. Hospitals may need help in understanding the emotional needs of mothers and children so that barriers to the normal mother-child relationship and to normal child development are not unwittingly established Shortages of personnel may force hospitals to consider simpler—and perhaps in the long run more satisfactory — care for mother and baby.

There is reason to believe that the standards and recommendations for care of newborn infants in hospitals, originally produced by the Children's Bureau and later revised and issued by the American Academy of Pediatrics, have been helpful to States in encouraging hospitals to improve conditions in their nurseries. At present the Children's Bureau is working with the American Academy of Pediatrics on a companion bulletin dealing with the pediatric units in general hospitals.

What about the child-health conference?

For many years one of the major tools of the maternal and child-health program has been the child-health conference. Its original purpose was, of course, to reduce infant mortality. Today, with the great reduction in infant mortality and the change in emphasis that has taken place in child-health programs, the work of the child-health conference is directed more toward helping parents with normal everyday problems in the growth and development of their children. It is time we should ask whether the child-health conference is still an effective tool for this purpose. Does it need revamping? What staffing is desirable today? These are things that need study. In the meantime the Children's Bureau has been cooperating with the Child Health Committee of the American Public Health Association on a manual bringing together what is known about good practice today.

In recent years much progress has been made in evaluating health services for the child of school age, both those within the school itself and those provided by the community. The draft for military service and the discussions on uni-

versal military training have again focused attention on the shortcomings of health and medical services provided for young people of secondary-school age. We are reminded of the lessons learned from the Public Health Service studies of children of school age in Hagerstown, Md., and the findings of the examinations of certain of these same people when drafted for World War II. Similar projects undertaken in other States in different ways and under a variety of conditions would add immeasurably to our knowledge of how to meet the health needs of school-age children.

The new statement sponsored jointly by the National Council of Chief State School Officers and the Association of State and Territorial Health Officers on "Responsibilities of State Departments of Education and Health for School Health Services" will help to focus attention on how these services can go forward. The Federal Security Agency Committee on Health Services for School-age Children, on which the Public Health Service, the Office of Education, and the Children's Bureau are represented, is about to issue a publication called "Better Health for School-age Children." It includes practical suggestions on how communities can figure out for themselves which things most need doing.

As communities give more careful and inclusive consideration to day-care centers for children of working mothers, foster-family care, adoption service, institutional care, services for juvenile delinquents, they find that health services and medical care are essential to well-rounded programs in these fields. State and local health agencies are cooperating increasingly with State and local education and welfare agencies, with State youth authorities, and with law-enforcement agencies such as juvenile courts, on the physical- and mental-health aspects of their programs. But only a beginning has been made. In many institutions for children, including training schools for delinquent boys or girls, health services are inadequately provided.

In this connection may I remind you that Federal-State funds for maternal- and child-health and crippled children's services may be used to assist other State and local agencies in developing adequate health and medical services for children and young people coming within their scope. Under the recently enacted Defense Housing and Community Facilities and Services Act, day-care centers for children of working mothers may be aided by Federal funds if and when such funds are appropriated. Of course maternal and child-health funds can be used at this time to provide the health services required for day-care centers, and indeed for any maternity or child-health service required in communities affected by either industrial or military defense activities.

Public and private agencies join hands

Undoubtedly the Midcentury White House Conference on Children and Youth did much to stimulate widespread consideration of the multiprofessional approach to the needs of children and increased cooperation among public and voluntary agencies. In many States committees on children and youth will continue to provide the opportunity for such joint planning. State and local health agencies can do much to stimulate the work of these committees.

With respect to the State programs for care of crippled children, the improvements are of many kinds. Altogether 215,000 children were cared for in 1950, an increase of 18 percent over the number the year before. Although children with orthopedic conditions still make up a large proportion of the total number treated under the State programs, it is heartening to see the way State agencies are broadening their programs beyond orthopedic services to include care for children with many different kinds of handicapping conditions.

Epileptic children are among the most recent to be included in crippled children's programs. Services for them offer a very good example of the importance of close teamwork between health services and the community. Diagnosis and treatment to control seizures are only part of the help an epileptic child needs. It is just as important that the community open its doors to him so that he can have the same chance for development other children have. Too often the epileptic child is treated as an outcast. To develop better community understanding and to train more workers in this field, two State agencies are assisting medical schools in providing courses for physicians, nurses, social workers, and others. As workers are trained, services for epileptic children can expand.

Some States are doing fine things for children with impaired hearing. So much can be done for these children now that was never possible before! Already a few States are assisting universities to train more audiologists. Techniques of diagnosis in children as young as 1 and 2 years of age have improved enormously. Various drugs and antibiotics can now be used to prevent permanent damage in many children with nose, throat, and ear infections. Hearing aids can be adjusted for children even 2 and 3 years old. Here is an opportunity for maternal- and child-health and crippled children's programs that is exciting.

A vast majority of the 175,000 children with cerebral palsy can benefit enormously from skilled help, but only a fraction are getting it. The kind of help they should have is medical, social, psychological, and educational. About a dozen State agencies have developed comprehensive programs for these children, usually geographically limited, including physician's

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Excerpted from a paper given at the annual conference of the Surgeon General of the Public Health Service and the Chief of the Children's Bureau with the Association of State and Territorial Health Officers, State Mental Health Authorities, and State Hospital Survey and Construction Authorities, November 26, 1951, held at Washington.

care; physical, occupational, and speech therapy; medical social services; public-health nursing; and special teaching arrangements. Comprehensive programs such as these are needed in other States.

At present 26 State health departments and crippled children's agencies have programs for the care of children with rheumatic fever. In most cases these programs were organized to demonstrate desirable kinds of care and to reach children in limited areas only. In a few cases State funds have been used to expand the program on a Statewide basis. Chemotherapy and antibiotics hold great promise of reducing the number of recurrent attacks and deaths from this disease. It is possible that the development of ACTH and cortisone treatment may change the whole pattern of therapy. But despite these advances in therapy, rheumatic fever is still a serious threat to children; it still stands highest among diseases causing the death of children of school age. The fact that so many States have undertaken to demonstrate care shows how wide the interest is. It is now the policy of the Children's Bureau to withdraw gradually the funds especially reserved for these programs. However, it is hoped that States having these projects will carry them on and expand them by seeking State funds as well as by using some of their regular Federal funds.

New methods of diagnosis and treatment are being developed on all sides. One such development in the field of congenital heart disease offers the hope of health and life itself to many children. But not every State has the highly trained specialists needed to give this care. In order to give this care now to children in such States, the sensible solution is to set up regional programs so that States without facilities can refer their children to an outstanding center in a nearby State. This is now being done. Connecticut has set up the machinery for the first of such regional programs. California will probably be next. When the Nation-wide planning is complete there should be five or six such regional programs strategically placed so that children with congenital heart disease in every State in the Union may have access to specialized diagnosis and surgery.

This device of pooling resources on a regional basis has large promise, too, for the care of children with other types of handicaps which call for highly skilled treatment such as cleft lip and cleft palate. It also has great significance for other types of regional planning. For example, establishment and use of education and training programs, the sharing of special consultants, and the use of special diagnostic and treatment facilities by two or three States. Such pooling of resources would mean that individual States would not have to maintain separate facilities and services that are uneconomical and possibly inferior in quality.

To find and train workers

Cutting across all phases of both the maternal- and child-health and crippled children's programs is the question of recruiting and training more and better personnel. This, I believe, is the number one problem in advancing child-health work. It is both a long-range one and an immediate one.

The types of professional and technical personnel required for the basic maternal- and child-health program and for the many different kinds of special services that are desirable if a well-rounded program is to be provided are varied. Acquiring such skills often calls for many months or even years of special training. All workers need periodic refreshment and time to catch up with the newer knowledge and skills in their special fields.

Extraordinary progress has been made in the last decade in providing training for physicians in maternal- and child-health work by some schools of public health, and in pediatric and maternity nursing by a number of schools of nursing. Special opportunities have been made available for training in highly specialized clinical and health fields, such as audiology, the treatment of rheumatic fever and congenital heart disease, the care of premature infants, epilepsy, and cerebral palsy. But still there is a great shortage of physicians to administer maternal- and child-health and crippled children's programs—physicians who have both clinical and public-health training. There is a shortage, too, of many other workers who are needed in children's programs, such as specially prepared pediatric and maternity nurses, medical social workers, and nutritionists.

We need a long-range plan of work with universities and colleges, with schools of medicine, nursing, and social work, to recruit personnel to enter the child-health field. Joint planning between undergraduate and graduate schools is necessary. Undergraduate curricula should be developed to attract new students to prepare themselves for graduate work. Economic, racial, and sex barriers will have to be broken down. Pay and working conditions will have to be made more attractive. More funds will have to be made available to enable educational institutions to strengthen their faculties with competent teachers in maternal and child health and in the related fields of nursing, medical social work, nutrition, health education, and the social sciences.

Training programs should be flexible

Professional schools are realizing the need for including instruction on child growth and development to give workers the newer concepts of physical, mental, and social health. New recruits to the field of child health must be as sensitive to the emotional needs of children as they are to their physical management. If the States want a well-trained and experienced child-health staff, serious attention will have to be given to ways and means of further strengthening educational institutions and of increasing the flexibility of training programs provided from funds for maternal- and

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WHILE A CHILD STAYS IN A FOSTER-FAMILY HOME

The agency that places him helps him, his parents, and his foster parents

ELIZABETH K. RADINSKY

THEY COME—not always one by one—these children who cannot stay where they are when we first see them. They must have substitute homes. Placing a child in foster care affords him at best only a substitute setting for his growth and development. We cannot make up to the child for the loss of his own home, or to the parents for the loss of some of their parental responsibilities and satisfactions — that we know. How, then, can our case-work service help child and parents?

For better parent-child relations

The child in foster care is helped to grow and develop normally in an atmosphere of understanding, affection, and wise discipline. At the same time he is helped to keep all that is beneficial in his relations with his own parents. Every effort is made to give him the right setting for working out his difficulties and for enjoying a child's usual activities with other children.

The parents are helped to develop the satisfying relations with their child that are natural between parents and children. While they are learning what it is to be responsible for the well-being of their child, they are letting him benefit from living in a foster-family home. From the records of the stream of children that flows constantly to our agency I am choosing the stories of four boys to try to give you an idea of our services to the many. But first I want to discuss the principles underlying the work of our agency. These principles are the same for all the children in our care, but the services are moulded to the situation and the needs of each child.

Our aim is to help each child get back to his own family as soon as it is beneficial for him to go. How long this will take cannot be predicted when we make the placement. Some parents ask to have their children placed in order to gain a brief respite — a chance to get on their feet. But for other children there is no foreseeable end of placement. For each child the agency must determine whether foster-family care is what is best for him and also for his parents.

Parents come to our "intake unit" to discuss their difficulties or to ask for foster care for their children. One of our social case workers helps the parents to arrive at a decision about whether or not to let their child be placed in foster care for a while. If they decide that the child should be placed, the parents receive case-work service throughout the placement, and the child is away from them only long enough for them to bring about the change necessary to make a good home.

There are two aspects to placing a child in another family's home when he cannot stay with his own parents — his physical care and the case-work service we give to him and to his parents and to his foster parents.

We have a program of medical care, for example, carried out through our own clinic. The agen-

A child whose own home has been broken up may find in a foster-family home an opportunity to grow and develop in an atmosphere of understanding, affection, and wise discipline.

cy physician directs this service, of course. It is the case worker, however, who sees that the child and the foster parents make the best possible use of the medical service. She notices evidence on the part of any of the persons concerned of lack of response to doctor's orders, or of anxieties about health or illness that may be signals for case-work help.

Special case-work help needed

To clothe the boy or girl suitably is the agency's responsibility. Dissatisfaction with the clothing provided is frequently a symptom of dissatisfaction with the placement of the child in foster care. If so, it is a major signal for case-work help.

We have gradually increased our psychiatric service for children. The persons connected with a child in foster care, however, cannot make the most of this service without the help of a case worker. Psychotherapy may arouse a great deal of feeling, not only in the child but in his parents. The foster family, too, may question its own adequacy to serve a child who they know is receiving psychiatric service. The case worker attempts to understand the feeling of each about the service and to help each one accordingly.

The agency has learned how important it is for most of the children it places to be able to join social groups, and so we arrange for it. Many have profited greatly from being a member of a community center, a boy-scout troop, a drawing or a dancing class. After the worker makes sure of the cooperation of the parents and foster parents, she prepares the child for this new experience and arranges for him to go to the meetings. She also works with the leader of the group to make the child's membership benefit him as much as possible.

School vacations may offer an opportunity for a foster child to get helpful new experiences. Going to camp for the summer or by the day is a valuable experience for many of these disturbed children. For one it is perhaps just a good social experience; for another it means the advantage of a brief separation from overprotective foster parents. Still another child learns to assume more responsibility or to take an interest in children of his own age.

For many of our little children of the 3–5 age, especially the extremely hyperactive, disorganized, confused ones, going to nursery school has been an extremely beneficial experience. Then, too, the burden of care on the foster mother, so great with some of these children, is lessened by the child's going to nursery school.

We have expanded our tutoring programs for individual children of school age whose emotional upset has disturbed their ability to learn as normal children do. These educational programs are very costly, but the results have convinced us that the expenditure is worth making.

Those are the principles on which our agency operates in helping the parent and the child benefit from foster care. Two examples may show you how we put these principles into practice.

Johnny's mother died just after his fourth birthday. Six months later his father came to our agency asking us to find a place for the boy. Mr. R explained that the little boy had been living with an aunt since his mother's death but now the aunt was ill.

The father tried to explain his haste for placement by saying that he would make a home for Johnny as soon as he remarried. But he was obviously so grief-stricken over his wife's death that the worker thought this was just talk to gain time.

After the boy was safely in an emergency shelter home, the father was reluctant to return to our agency to arrange for a more suitable placement for his son. When he did come, he seemed unable to face the fact that he had to consider a long-term plan for Johnny. He acknowledged that he had no one in mind to marry — that taking a new wife was impossible for him to think of. He resisted the idea of placing the boy in a foster-family home, apparently fearing that he would lose his son to the foster parents.

The worker explained to the father that the agency believed that full-time care in a group was not good for a child as young as Johnny. She appreciated his anxiety but helped him to understand, in turn, the agency's desire to safeguard and nourish the close ties between him and his son. However, the worker explained, Johnny would need his help and the agency's to become rooted enough where he lived to be able to benefit from what a foster family could offer him. His father would have to approve of the foster parents and of Johnny's living with them if Johnny was to feel sure of their interest in him, of their authority over him, and of their responsibility to give him good care. Johnny was not likely to feel this security if, when his father came to see him, the father seemed anxious about their separation.

It takes time

The case worker knew that at first Mr. R actually feared the agency. Confidence in us and reliance on our judgment would develop, we hoped, in the course of time as we worked with Mr. R for Johnny's good.

The first time the worker went to see Johnny at the shelter home, she arranged for his father to be there to introduce her to the little boy. The worker and the father planned together in Johnny's presence for the worker's next meeting

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with Johnny, when she and Mr. R would take him to his new home with foster parents. The worker helped Mr. R tell Johnny that he would visit him there in 9 days, after Johnny had had a chance to get acquainted with the foster family.

During these 9 days, anxious ones for the father, the case worker kept in touch with him, and at regular intervals after that. These interviews gave him a chance to discuss anything that came up about his son's placement and how he felt about it.

Johnny acts up

At the same time the case worker was in close touch with the foster mother. There were two little girls in the family, one older than Johnny and one younger. The first 10 weeks of the boy's stay were extremely difficult for everyone in the family. The foster parents, who were having their first experience with someone else's child, found it wearing to listen to Johnny's constant talk of the house his father was building so that he could take Johnny home to live with him. The child tried their patience in many ways — especially when he deliberately broke his toys and tore his clothing. The worker urged the foster parents to keep on being patient with him, giving time a chance.

As the father grew to believe that family care was right for Johnny the little boy seemed to sense this and his own feelings began to change. He became less destructive and began to show affection. From then on the case worker's job was simpler. It is always easier to help foster parents when the foster child is responsive to their care of him.

It took 6 months for Johnny to settle down in his new home. Just then his father told the worker that he was thinking seriously of getting married. This time he really meant it, he said, and seemed very happy about it. He thought the girl would be a good mother to Johnny.

After the wedding was over, the case worker helped the father and his new wife plan for Johnny's return. She also helped the foster parents with their part in preparing the little boy for the change. For 3 months she worked to make sure that living in a different home would not interrupt the progress Johnny was making. After 9 months in the agency's care, Johnny went home.

It was fortunate that we had on our list this particular home for Johnny. Even so, as I have said, in a way the agency created it for him. The foster mother did have great difficulty with him at first but was able to bear his behavior when she felt sure that the agency knew that the little boy's difficulties had no connection with the kind of care he was getting. Relieved of this anxiety, the foster mother was able to show her natural affection for Johnny even while she was trying to set limits to his destructive activities. Other painful times were eased for the foster mother because the worker managed to get over to her full recognition of her achievement — how much she had helped the little boy. Together, all who were in close touch with the boy made it possible for him to go home able to fit smoothly into his new life.

Then a happy ending

This was a comparatively simple piece of work for the agency but a rewarding one, because the father finally recognized so clearly the value of the service to him. During one of the last interviews Mr. R said that, looking back on the year, he saw it was "a terrible but also a wonderful chapter of his life" that was closing. He realized that if he had persisted in his early determination not to place Johnny he could never have pulled himself together. The quality of Mr. R's parenthood, it is clear, was a very significant factor in the success of the placement.

In telling of Johnny's placement, a short and simple one, I have attempted to show something of case work in foster-family care. In the story of the L family, which follows, I can show very little of the case work because of the many complexities the agency had to meet during the 7 years of service. These three boys could not return to their own home because their father and mother did not grow to be even reasonably good parents to them. The principles of the work in both instances were the same but the details were very different.

Leonard was 9½ and the twins, Harold and Benjy, were 3½ when our agency first knew them. Their parents approved of it; though each a suitable home in spite of a family agency's efforts to help them. Now the mother was on the verge of a breakdown, and foster care for the children was imperative. Both parents approved of it; though each was violently blaming the other for making it necessary "to put the children away." The father was bitter toward his wife for her obvious neglect of the children, because the same thing — a broken home — had happened to him in his own childhood. He regretted it for his sons. His wife blamed him for the meagerness of his earnings, and each accused the other of infidelity. Neither parent seemed to understand what their sons needed in the way of physical care or of parental affection.

The boys showed evidence of severe physical neglect. We were fortunate in being able to place them with foster parents who knew how to work with us in clearing up serious eye infections, chronic coughs, and malnutrition. They could be patient with the children's habits of wetting and soiling themselves and with their violent quarrels. They could even bear the parents' frequent visits, although the children became uncontrollable after seeing either of them.

Our case worker saw each of the parents separately at regular intervals. She was trying to help them understand what children need from their parents. She started by trying to get the father and mother to stop deriding each other to the children and checking up on each other's conduct by asking the chil-

dren questions. She made little headway with this or with trying to limit the parents' visits to regular times.

After 9 months in the foster home the children showed impressive physical gains, except that the twins did not learn bladder control. But they quarreled incessantly. If anyone showed special attention to one, the reaction of the other two was violent. Yet they clung together in such a way that neither the case worker nor the foster parents could get close to any of them.

When, the second summer, the foster mother decided to go away on a long visit, the boys would have had to be placed in another home for that length of time. The agency decided to find two new homes, separating the twins from Leonard, who seemed to be the leader in the fighting.

Leonard seemed relieved when the worker discussed this suggestion with him and readily agreed to it. The parents thought well of the plan. Two homes were found near enough to each other so that the brothers could keep in close touch.

But Harold and Benjy continued to quarrel. So, after careful review, we decided to separate them. Benjy was the favorite in the neighborhood; this disturbed Harold. He would wander away from home and stay for hours, causing much worry, excitement, and trouble. When we talked to the twins about separating them — each to be in his own foster home — Harold was eager to leave but Benjy did not want him to go. However, when we took the responsibility of separating them and carried it out, Benjy was not disturbed. For 3 years now the twins have been in different homes and Leonard has been in his separate home for 6 years.

Leonard is now 16 and the twins are almost 11. During their years of foster-home care all 3 boys have shared 4 workers. The parents were not willing to relinquish the children for adoption and yet were not able to change so that they could create a stable environment in which their children could grow and develop in a healthy way. Yet the children obviously need both their parents and want to continue to be in touch with them.

Through summer day-camp activities a foster child may gain experiences that he needs.

Service to these children has taken a prodigious amount of their case worker's time. The twins have needed a great deal of medical attention. All three have had difficulty in school. The worker has had many conferences with our psychologist and our psychiatrist and the school authorities. She has worked with the four sets of foster parents. For example, Harold had to be tutored, the psychologist and the psychiatrist decided, to overcome a reading difficulty that made him hate school. When a tutor was selected, the worker found that Harold's foster father did not like it. He felt that bringing a psychiatrist, a psychologist, and a tutor into the picture reflected on him. Surely the agency must doubt his ability to help the boy. To get around this difficulty, the worker changed the plan; Harold's foster father did the tutoring.

Foster parents find some satisfaction

None of the workers has succeeded in helping the parents to seek some kind of therapy for themselves. We work with them within their limits, holding them to meagre responsibilities so they will not drift away from their sons. Leonard, Harold, and Benjy have been helped. Many of their behavior difficulties — serious at first—have lessened. Each boy has made a definite place for himself with his foster family. Benjy is the most responsive. Leonard and Harold too have foster parents who are fond of them, but the boys are unable to return the affection that they receive. The families are frustrated by the boys' indifference and their inability to accept the place in the family circle that could be theirs. The worker has helped the foster parents overcome their disappointment by finding satisfaction, instead, in what they have been able to achieve for the boys.

The worker has helped the three foster families take part in making

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BOYS AND BOOKS

(Continued from page 101)

each week. (This is in addition to the books read in the cottages.) An average of 12 boys take part in the evening library periods. And all day long boys can be seen in the library finding material for their classroom work or reading for pleasure."

Interested people have asked us how much the library program has helped to improve the boys' ability to read and to understand what they read. Of course, we really don't know the answer to that question, for the boys do not remain at the school long enough to take standard achievement tests repeatedly. (The average stay is 11 months.) In general their reading does show improvement, even though we do not attempt to attribute this specifically to the library program.

Books take part in treatment

One of the greatest values in the book program as part of the school's treatment plan for the boys is that often a book is shared with a staff member, and this forms a bond between child and adult — a common interest. We find that this understanding between the boy and a person of an older age group is a definite step in the direction of success in solving the boy's personality problems. When a boy talks about books with his therapist, his social worker, or his houseparent, a common meeting ground has been discovered.

We have made a special effort to use the book program as a strengthening factor in the tie between the school and the city where it is located. We have invited children and teachers from neighboring schools and other persons in the community who are interested in books to join with us in special book activities, and we feel that this is a step toward preparing our boys to return successfully to their own communities.

The book program began as an adventure, but after 4 years we look upon it as a strong contribution to the school's treatment program for the boys. And the boys look upon it as fun.

Here are some of the book lists from which our committee and our boys together select books for the school library:

Adventuring With Books; a reading list for elementary schools. National Council of Teachers of English, 211 West Sixty-eighth St., Chicago 21, Ill. 1950.

Basic book collections: For elementary grades; for junior high schools; and for high schools. American Library Association, 50 East Huron St., Chicago 11, Ill. 1950.

Book posters, promotional material. Children's Book Council, 62 West Forty-fifth St., New York 19, N. Y.

Boys' Own List of Favorite Books. Secondary Education Board, Milton 89, Mass. 1940.

Catalog 1951–52. Kansas State Reading Circle, 315 West Tenth St., Topeka, Kans.

Character Formation Through Books. Catholic University of America Press, Washington, D. C. (New edition in press.)

Children's Catalog. H. W. Wilson Co., New York, N. Y. (New edition in press.)

400 Books for Boys' Club Libraries. Boys' Clubs of America, 381 Fourth Ave., New York 16, N. Y. 1946.

Gateways to Readable Books, by Ruth Strang and others. H. W. Wilson Co., New York, N. Y. (New edition in preparation.)

Good Books for Boys, 1951. Boy Scouts of America, 2 Park Ave., New York 16, N.Y.

Reading Ladders for Human Relations. National Council of Teachers of English, 211 West Sixty-eighth St., Chicago 21, Ill. 1947.

Stories; a list of stories to tell and to read aloud. New York Public Library. 1949.

Stories to Tell to Children. Carnegie Library of Pittsburgh. 1949.

Standard Catalog for High School Libraries. H. W. Wilson Co., New York, N. Y. 1947.

Train and Engine Books for Children. Association of American Railroads, Washington, D. C. 1951.

Treasure for the Taking, by Anne Thaxter Eaton. Viking Press, New York, N. Y. 1946.

We Build Together (revised edition). National Council of Teachers of English, 211 West Sixty-eighth St., Chicago 21, Ill. 1941.

Reprints in about 6 weeks

MCH AND CC

(Continued from page 104)

child-health and crippled children's services. This flexibility should provide for each individual the training and experience he needs for his particular type of job, and for teams of workers in specific programs, such as those dealing with cerebral palsy, rheumatic fever, and prematurity. The opportunity for joint training will increase their understanding of each other's jobs and multiply their effectiveness as a team. To make this training count, health administrators need to be oriented sufficiently in the content of programs to assist the individuals and the team in the effective implementation of their new skills and insights.

Children's bureau will help and advise

Second only to a satisfactory program of recruitment and training is the research necessary to obtain new facts on which new or modified programs can be based, and to evaluate the progress, quality, effectiveness, and cost of on-going work. Increasingly State agencies are becoming interested in studying and evaluating their own programs. This type of research calls for technical skills, new methods, and careful preliminary planning of projects with a view to later evaluation. It should include not only studies of the effectiveness of programs, of administrative and of medical and social techniques, but evaluation of expenditures for programs in terms of gains in health and well-being of children. I recognize that it is difficult to devise scientific methods by which the effectiveness of public-health and welfare measures can be tested or judged, but I believe the States have an obligation to one another to show as far as possible what is productive and what is unproductive in the way they work. Within its resources the Children's Bureau stands ready to assist and to advise on ways and means of making such evaluations.

FOSTER-FAMILY CARE

(Continued from page 108)

it possible for Benjy and Harold to spend many week ends together in each other's foster homes. They go away to camp together in the summer.

Leonard's emotional confusion about being away from his parents has become intensified during his adolescence. He has become more and more indifferent to his foster parents' interest in him. This, the worker reminds them, is partly the adolescent's struggle for independence and partly the old conflict between his loyalty to them and to his own parents.

What is the answer?

Does our kind of service — foster-family care — intensify the conflicts of children such as these? Would they be better off in an institution? We have asked ourselves this question many times, examining the value of our service to Leonard, Harold, and Benjy. Our decision to continue family care was always based on our belief that the flow of what they have gained from living in family homes would be interrupted by placing them in an institution.

The two situations I have described do not, naturally, represent all the types of situations we deal with. Yet they do show how greatly individuals differ in their capacity to become good fathers and mothers under difficult circumstances. The agency has learned from its experience that as we make case work available to a troubled parent, we find out the depth of that parent's desire to have good relations with the children and his power to develop these relations.

Our specific aims are different, to be sure, for each boy and girl we place in a foster-family home. But our general aim is the same for all — to give them an opportunity to develop normally, to become their best selves in spite of a damaging experience at the start.

Reprints in about 6 weeks

IN THE NEWS

Accidents continue to kill more children past infancy than any other cause. It is true that the death rate from this cause declined slightly between 1939 and 1949, the latest year for which figures are available. The decrease was from 37 to 32 deaths per 100,000 children in the age group 1-19. But the rate did not decline in all age groups; it increased from 45 to 47 among boys and girls 15-19 years of age. Among children 5-14 years of age the rate decreased from 28 to 23; among those 1-4, from 52 to 38.

Handicapped children. A year's student of the qualifications and preparation of teachers of the Nation's nearly 5,000,000 school-age exceptional children will soon be begun by the Office of Education, Federal Security Agency. The study has been made possible through a grant of $25,500 from the Association for the Aid of Crippled Children (New York State). Progress reports and publications presenting study findings will be issued from time to time during the year.

Mental health. The National Association for Mental Health has announced an award of $1,000 for the best report on clinical research that will advance our knowledge and understanding of adolescents and of the ways in which we can help them in their social and emotional adjustment. Further information may be had from the Association, 1790 Broadway, New York 19, N. Y.

Insurance benefits. Three out of four mothers and children in the United States are now protected by Old-Age and Survivors Insurance and would receive monthly payments if the wage-earner in the family died. These benefits to survivors are one part of the Federal social security system. This particular insurance protection now has a face value of $200 billion.

The extent of this insurance is a good index to the Nation's progress in protecting families against loss of income caused by old age or death of the family breadwinner. It is important not only to those whose work is covered by the law, but to all of us—for the security of each must concern us all.

The value of this insurance to the average family is great. In case of the wage-earner's death the typical family finds that Old-Age and Survivors Insurance has a greater cash value than all other assets. Monthly payments to a family, totaled over a period of years, may be as much as $25,000 or even more, and there are many thousands of families whose total benefits will be more than $10,000.

Sixty-two million workers are now insured under the program. People of all ages are receiving the insurance payments. In 1951 young widows and their children received $360 million.

Head, hands, health, heart. The Post Office Department has issued a special commemorative 3-cent stamp honoring the 4–H Club movement. The stamp, which is green, shows a farm picture; a teen-age boy and girl; the four-leaf clover symbol of 4-H; and the club's motto, "Make the Best Better."

The stamp went on sale January 15 at Springfield, Ohio, because Ohio is observing the fiftieth anniversary of the organization in that city of its first rural boys' and girls' agricultural club, on January 15, 1902. This was one of several similar undertakings in a number of States, which grew later into what is now known as 4 H Club work.

Under the provisions of the Smith-Lever and other acts of Congress, 4-H Club work is a part of the cooperative extension system in which the U. S. Department of Agriculture, the land-grant colleges, and the agricultural counties cooperate.

India. UNICEF has provided $525.000 for 150 medical units, which will serve as mobile child-welfare and maternity-health centers in villages in India.

Illustrations:

Cover, Esther Bubley for Young America Magazine.

Pages 98, 99, and 101, courtesy of the author.

Page 108, courtesy of Day Camp Unit of the Division of Day Care and Foster Homes of the New York City Department of Health.

To Our Readers—

We welcome comments and suggestions about **The Child.**

FOR YOUR BOOKSHELF

UNDERSTANDING YOUR SON'S ADOLESCENCE. By J. Roswell Gallagher, M.D. Little, Brown and Co., Boston, Mass. 1951. 212 pp. $3.

When I was a high-school student, my algebra teacher, a true philosopher, once remarked that common sense is the scarcest thing in the world. Through the years I have had occasion to remember this (although little of the algebra), and the words of the teacher return to mind as I review Dr. Gallagher's chapters.

Here, indeed, is rare common sense. Wisely, Dr. Gallagher limits himself to a discussion of a few fundamental principles relating to the physical, emotional, and behavior problems that arise in the adolescent boy off to school.

In an engaging manner he illustrates his subjects from various angles so that a clear-cut picture of the problem at hand is obtained, with a welcome economy of words.

Again and again he is able to summarize his topic in a few words. In the chapter, "There Is No Average Boy," he says, "No one ever did adolescents a greater disservice than the person who initiated the idea that there is an average weight, or height, or grade level in school for any age, or that there is an average age at which boys should take responsibility, drive cars, stay out late, or shave. He has burdened the adolescent boy with unnecessary worry. The fact is that wide ranges exist in all these matters in perfectly normal boys." This kind of forthright expression appears throughout the book.

The book is meant for lay reading, but it will also be useful to professional workers who deal with adolescents. Such chapters as "They're Trying to Grow Up," "Sex Is Necessary," and "Why They Misbehave," will appeal to the professional reader.

Robert W. Culbert, M.D.

JUVENILE COURT LAWS IN FOREIGN COUNTRIES. By Anna Kalet Smith. Federal Security Agency, Children's Bureau Publication No. 328, Revised. Washington, 1951. 76 pp. 25 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

In this revision, recent changes in the laws have been incorporated in the chapters on a number of countries, among them Czechoslovakia, Germany, Great Britain, Hungary, and Yugoslavia. Laws of two countries, Egypt and Federation of Malaya, not represented in the first edition, have been added.

PERSONNEL IN PUBLIC CHILD-WELFARE PROGRAMS, 1950. Children's Bureau Statistical Series No. 7. Federal Security Agency, Social Security Administration, Children's Bureau. Washington, 1951. Processed. 15 pp. Single copies free.

An increase of 8 percent over the previous fiscal year in the number of full-time professional employees in public child-welfare programs is reported in this bulletin. Figures are given on number and location of these employees, types of positions held, staff turnover, service loads, salaries, and source of funds from which salaries are paid.

More full-time professional child-welfare employees were paid from State and local funds in 1950 than in 1949, according to the bulletin. In 1950 more Federal funds were used for educational leave, for professional conferences and institutes, and for special State services and projects designed to strengthen and extend services for children.

A steady upward trend took place in the number of public child-welfare workers over the past 5 years; this was due partly to an increase in 1946 of about $2,000,000 annually in the Federal appropriation for such services under title V, part 3, of the Social Security Act. The study does not reflect further increased funds made available under the August 1950 amendments to the Social Security Act.

The more than 4,100 full-time professional child-welfare employees of State and local agencies provide services to children in their own homes who have emotional problems or who are neglected, abused, or in danger of becoming delinquent, children who are being adopted, children who require foster care because they cannot remain in their own homes, and unmarried mothers and their babies.

CALENDAR

(Continued from page 112)

Regional conferences, Child Welfare League of America:

Apr. 27–29. Southwest Region. Austin, Tex.

May 1–3. South Pacific Region. Long Beach, Calif.

June 9–10. New England Region. Poland Springs, Me.

Sept. 25–27. Midwest Region. Des Moines, Iowa.

Regional meetings, American Public Health Association:

Apr. 17–19. Southern Branch. Baltimore, Md.

June 3–6. Western Branch. Denver, Colo.

Regional conference, American Public Welfare Association:

Apr. 6–8. Central Region. St. Louis, Mo.

THE CHILD

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

• CALENDAR

Apr. 7. World Health Day.

Apr. 7–10. American Association for Health, Physical Education, and Recreation (a department of the National Education Association). Fifty-seventh annual convention. Los Angeles, Calif.

Apr. 14–18. Association for Childhood Education International. Annual study conference. Philadelphia, Pa.

Apr. 15–19. American Camping Association. Twenty-second national convention. Chicago, Ill.

Apr. 17–19. Girls Clubs of America, Inc. Seventh annual conference. New York, N. Y.

Apr. 17–20. American Heart Association. Twenty-eighth annual meeting and twenty-fifth scientific session. Cleveland, Ohio.

Apr. 18–19. American Academy of Political and Social Science. Fifty-sixth annual meeting. Philadelphia, Pa.

Apr. 20–26. National YWCA Week. Fifth annual observance. Information from National Board, Young Women's Christian Association, 600 Lexington Avenue, New York 22, N. Y.

Apr. 21–23. Fifteenth Annual Groves Conference on Marriage and the Family. Durham, N. C. Sponsored by North Carolina College and the University of North Carolina. (Formerly held in two sections, one at Chapel Hill and the other at Durham.)

Apr. 23. Social Hygiene Day. Information from the American Social Hygiene Association, 1700 Broadway, New York 19, N. Y.

Apr. 25–26. American Association for Cleft Palate Rehabilitation. Tenth annual meeting. St. Louis, Mo.

Apr. 26–May 3. Boys and Girls Week. Information from Rotary International, 35 East Wacker Drive, Chicago 1, Ill.

Apr. 30–May 3. International Council for Exceptional Children. Thirtieth annual meeting. Omaha, Nebr.

U.S. GOVERNMENT PRINTING OFFICE: 1952–952607

THE CHILD

APRIL
1952

HELPING HOSPITALIZED CHILDREN THROUGH SOCIAL GROUP WORK

GRACE L. COYLE and RAYMOND FISHER

WHEN a social group worker joins the staff of a children's hospital, he is likely to be viewed at first as responsible chiefly for providing a recreation program. This is natural, as some hospitals have an already established staff position—recreation worker or recreation therapist—into which he steps. It is obviously essential that he know how to organize recreation groups of various kinds suitable to hospital conditions and how to carry out a good recreation program.

As our experience shows, however, such a worker needs to know a great deal more than that. He must, first of all, be able to gain an understanding of each child as an individual. For behind the sullen apathy of Johnny, lodged in his wheelchair, or of Jimmy ruling the ward like a despot as he has always ruled the playground, the social group worker must recognize the distinctive elements in the personality of each of these children, as he struggles to grow up and adjust to the separation from his parents and friends, to the frustration of illness, and to the strange environment of the hospital.

It is always a temptation to a specialist to look at other people through his special lenses; but if the recreation worker regards a child chiefly as a member of a team, or a potential producer of ceramics, or a good lead for a play, he will miss his major opportunity. Rather he must see the child as a whole, with his family background and cultural pattern, with his particular illness and its meaning to him. He can then establish a relationship with the child and help him to use the recreation activities not only as a means of enjoyment but as a help to recovery.

Such a worker must know what he means to the child and how and why the child is reacting to him in a particular way. He has to be able to handle the children's reactions—by turns hostile, overenthusiastic, indifferent, ingratiating, suspicious, or accepting. He will find himself sometimes cast in the role of a substitute parent. Sometimes he will represent a means of escape and a source of pleasure. Occasionally he will need to explain to a child the restrictions and constraints of the medical treatment and hospital care.

Penetration into this vital life stream of a child's world and finding a welcome place in it gives the recreation worker an opportunity to make the child's environment a more relaxed, more accepting, and more satisfying one. Because hospital administrators recognize that a recreation worker needs to understand a child's problems and needs to know how to help him by means of group experiences, they have been seeking professionally trained social group workers to develop the recreation program and related programs as part of the functions of the hospital's social-service department.

The function of the social group worker in a hospital has a basic similarity to his function in any other setting. It is to help individuals, by means of guided group experience, to develop and use their capacities for personally satisfying social relationships; to help them to deal with the problems presented by their environment and to use the resources of this environment in a constructive way. As a result of these positive, progressive experiences the persons who take part in them are enabled to carry more effectively their responsibilities in a democratic society.

In applying these general, basic principles to the specifics of working with hospitalized children, we must clearly understand several considerations that make for some differences in the worker's approach and emphasis in his relationship to his groups and to the members. In the hospital the social group worker represents one of a number of professional disciplines working in cooperation with the physician, who is the key person responsible for the patients. The group worker's function as a member of the social-service department has to be related to

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This article is based by Miss Coyle and Mr. Fisher on a paper that they prepared for the Midcentury White House Conference on Children and Youth. The paper is one of a number that served as resource material for the Fact Finding Report of the Midcentury White House Conference on Children and Youth, to be published soon by Harper & Bros. The procedures of the conference did not provide for official approval of these papers. Address inquiries to National Midcentury Committee for Children and Youth, 160 Broadway, New New York 38, N. Y.

Each child's personality has distinctive elements, and these need to be recognized by the social group worker in her efforts to help the children adjust themselves to separation from their parents, to the frustrations of illness, and to the strange environment of the hospital.

the services offered by the hospital and be a part of those services.

Another consideration is the impact of the child's illness and hospitalization and its meaning to him. Illness necessitating hospitalization has psychological implications for a child that need to be understood by persons responsible for his care. Separation from the family is a traumatic experience for children, and the shift from home to hospital brings with it many fantasies and anxieties. Removal from home is often viewed by the child as rejection, and the hospital experience as punishment.

To help children handle their feelings

To a child, a hospital can be a strange and fearful place. Besides being unknown, and possibly representing punishment, the regimented and authoritative aspects of hospital routine (often incomprehensible to the child) make it even more forbidding. The treatment may frighten him, and the pain and anxieties related to the illness itself are often overwhelming. Recognizing this, the social group worker will help a child become acquainted with the hospital and will deal with his feelings of anxiety and fear.

In one hospital for acutely ill children, where the average length of stay was less than a week, the social group worker made it a practice of visiting each child before each group meeting to tell him that the meeting would be held on the ward and to ask what he would like most to do.

She found that often children in adjoining beds could not bring themselves to speak to one another until she introduced them and helped them to become acquainted through relaxed play activities.

The social group worker purposely kept the program very flexible and helped the children decide between such activities as arts and crafts, music, games, discussions, and dramatics.

Sometimes a gift that parents brought set the keynote for the activity. A little girl's cowboy suit, for example, gave the children the idea that they wanted to put on a "wildest west" play. Again, a stuffed animal provided the germ of an idea around which a jungle play could be formed. More often, plays centering about the children's present experiences with illness and treatment were the most popular activity. In these, the children brought out clearly and repeatedly their feelings of anxiety about illness. They dramatized hospital and medical procedures, such as shots, electroencephalograms, and X-rays. They acted out separation from the family and showed the meaning of hospitalization to them.

Often the children would interrupt the play to discuss what they had spontaneously acted out, and would consider whether it was real or make-believe.

In one play the children were showing what happened to put a child in the hospital. The first scene was in the boy's home. He had a minor illness and a doctor was called. Pills were prescribed, but this boy was "bad" and ate more of those "delicious" pills than he was supposed to and as a result had to be hospitalized.

The play was interrupted at this point because the children were interested in talking about whether only bad children were sent to hospitals. This afforded the group worker an opportunity to give them considerable reassurance that they were not being punished, even though she sympathized with them for the treatment they had to endure.

The group then spontaneously continued with the play, this time shifting the scene to the hospital, with the nurses and doctors giving "shots," the nurse giving the little ones and the doctor the big ones. The scene ended with all the children taking turns giving each other shots with clay needles that one of them had been busy preparing.

Through such group sessions the children may be helped to handle their feelings about what has happened to them and may be prepared for procedures that are to come. In their plays centering about the hospital, they think through their feelings instead of repressing them.

They change from the passive role of the patient to the active one of the doctor or nurse, thus reversing the roles and becoming the powerful person who is in control of the situation. They are helped to talk through, or act out, some of their anxieties and, through sharing their feelings, to get acceptance and support from one another.

Children share experiences

Thus the children are helped to identify with each other on the basis of their sharing difficult experiences (hospitalization, treatment, and separation from families, and their anxieties about these) and sharing also the pleasurable experiences stimulated by the group worker. The group worker represents the warm, sympathetic, and concerned adult; she helps the children to develop a strong bond as they join together in the pleasurable activities.

Endowment of the social group worker with the role of the mother is sometimes even recognized by the children. For example, a 6-year-old boy came running to the group worker when she came on the ward, embraced her, and said he didn't feel too bad that his mother lived too far away to visit him daily because he knew that his "play lady" would come.

Another little boy invariably cried when the worker left the ward after a group session. Finally an 8-year-old took it upon himself to explain to the worker that this boy cried each time his mother left, and also when the worker left, because the worker was "like his mother to him." (These examples occurred during a group-work demonstration by Constance Impallaria, Assistant Professor of Psychiatric Group Work, School of Applied Social Sciences, Western Reserve University.)

A social group worker needs to be able to recognize and understand the relations that inevitably develop among children. Each ward becomes a small social world of its own, and as patients come and go, that world shifts in important ways for every child. (This is true in any hospital but may present special problems in a hospital that provides for long-term treatment and convalescent care.)

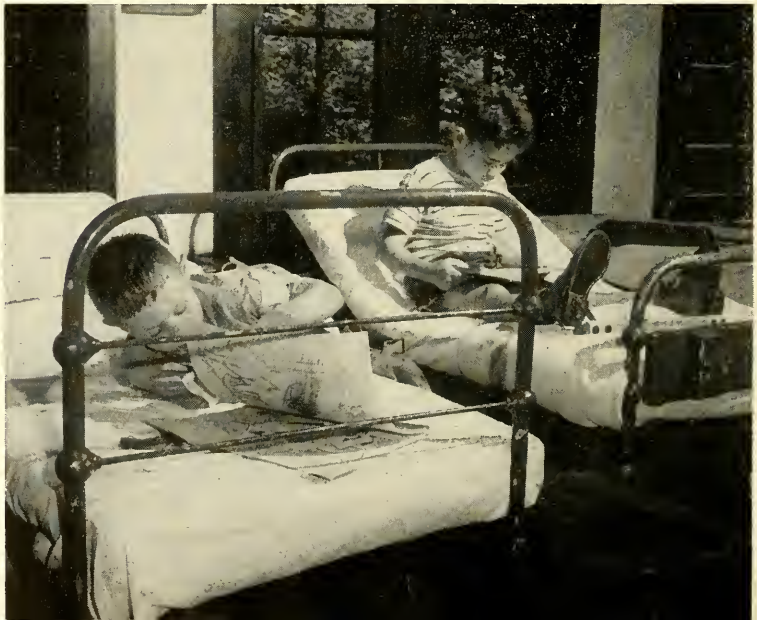
In one corner of a ward, for example, three small girls have established a close-knit subgroup, within which, in spite of occasional squabbles, their mutual support gives each some much-needed affection. Behind this transparent but seemingly impenetrable curtain, which is evident to every other child in the ward, the three have their own special island. From there they throw their barbs of ridicule at the new child in the next bed; they test the nurse to see how far they can go. No child in the ward escapes their scrutiny, and within this small world they are both feared and envied.

Again, in an orthopedic ward, a "newspaper group" of adolescents has been established by the social group worker to give aspiring writers their chance as well as to provide news for the children in the hospital. Within this group another drama goes on. To the group worker, in his daily contacts, it is obvious that among these permanently handicapped boys and girls, as among other young people, romance is budding. Rosalee, depositing her monthly contribution of what she terms "love stuff," and Bobby, turning in his sport column, are also testing their capacities to be like other young people, outside the hospital.

As in any institutional setting for children, at times unhealthy group relations develop, which require special treatment. Such a situation may occur if a group initiates newcomers into sex play; it may show itself in an outburst of behavior problems on a particular ward; it may appear as continued persecution of one unfortunate child, who acts as scapegoat for the group's frustration. Such manifestations represent a group problem. They cannot be handled on an individual basis alone; they must be understood and worked with as group interactions. Some patients may need the individual services of a medical social worker or a psychiatrist, or both, but in addition the network of relations must be kept in mind by the group worker. He must understand the attachment of certain children to subgroups; the roles of the leaders and of their followers, of the isolates and of the heroes; the conspiracies against authority; the subtle ebb and flow of morale in all the groups involved.

Social group-work skill can help the children who have very difficult problems concerning their illness. Older boys, for example, may be

Sometimes youngsters who are in a hospital need help in getting acquainted with each other.



seriously disturbed about the relation of their illness to normal masculinity. Again, children with diabetes, or with an abnormal cardiac condition, may need help in learning to function within the limitations imposed by the illness. The information about the disease, of course, must come from the medical staff. But such information often needs to be supplemented, and a helpful way to do this is through informal discussion groups led by a social group worker who understands children and who is trained in handling discussion.

Such a worker encourages participation by the youngsters and helps them express their feelings and ideas. In this atmosphere the worker can reassure the young patient as much as is consistent with the facts. The therapeutic value of the renewed confidence that children get from such discussions is not yet widely enough recognized.

Initiative encouraged

Another aspect of hospital life that social group workers must deal with is related to control of behavior problems. In a hospital, medical necessity establishes certain requirements. And many of the behavior problems that arise among hospitalized children are merely those that any child might present, exaggerated, of course, by the results of illness and the restrictions caused by hospital requirements. These problems must be met, but exercise of authority for its own sake, with its overtones of punishment and hostility, obviously does not contribute to a healthy social atmosphere. More successful is constructive use of permissiveness and authority, in proportion as each is needed.

Giving responsibility for parts of the recreation program to self-governed planning committees of children is a device that has been carried over successfully from camps and other groups into hospitals. Such committees are described in an unpublished thesis by Maree Brower, "While Patients Play." (School of Applied Social Sciences, Western Reserve University, Cleveland, Ohio, 1948.) An article based on this thesis was published in **The Child,** October 1950, under the title, "Encouraging Initiative in Convalescent Children."

Self-determination of this sort helps to prevent the increasing dependence, or regression to infantile behavior, that sometimes comes with illness. The spirit of such an approach could well permeate the administration of the hospital as a whole in its dealing with children.

Such recognition and understanding of the social problems that develop in a hospital represents one of the major kinds of help that the social group worker can give a child. This can be done as plans are made for treatment, not only directly, but also indirectly through the other members of the medical team—the doctor, the nurse, and the medical social worker.

Restoration of a child's health can be aided through group work with parents or other relatives. Such groups may meet to discuss common problems in caring for their sick children. These problems might include, for example, how to treat a handicapped child after he returns home, or what help he needs in adjusting to his return to school. Parents often find that the support they give one another strengthens their efforts to help their children toward recovery.

In suggesting these special types of groups, which can and should be developed by group workers in hospitals according to the setting and the need, we are assuming that the social group worker is a trained social worker. Such a worker, like a medical social worker, is equipped with psychiatric knowledge, medical information, and skill in helping people, as well as an understanding of himself; his special skill lies, of course, in his ability to help people primarily through group relations.

It is essential for the social group worker to be able to relate himself helpfully to the hospital as a whole and to the other members of the staff. To do this most effectively he should, we believe, be functioning as a part of the social-service department. Where group workers and case workers operate together they invariably make referrals to one another and share their observations and special knowledge about the children. The result is that some children receive help from both, with each specialist—group worker and case worker—operating more effectively as a result of the joint effort. Consciousness of his own role in meeting the needs of children in a hospital and the ability to work within it is the mark of the successfully trained worker.

The worker must be aware of his function as it relates to that of other people, such as doctors, nurses, attendants, and physical and occupational therapists. In staff meetings or conferences, with medical personnel for example, the social group worker is often able to contribute to diagnostic thinking, through observing the individual child's reaction in the group. He contributes also his knowledge of the social and emotional implications of the hospital experience for the children through sharing with them illustrative material that has come out in group play or group discussion. The social group worker can also take a responsible part in treatment when a doctor suggests that group experience may prove helpful in meeting the needs of a particular child.

Toward harmony in the group

Another way in which a social group worker should be helpful is in placing a child in a suitable ward group. It is not enough to consider his placement in terms of age, sex, and disease. A factor of major importance to his happiness and perhaps to his recovery is how well he as a person will fit in with the other children into whose social world he is suddenly wheeled. In the children's institution and the camp, we are discovering the importance of skill in grouping. We know that a misplaced child can ruin a harmonious cottage, or a seriously withdrawn child may be subjected to harsh treatment because adults are not alert to the full significance of

(Continued on page 126)

FOR THE HEALTH OF WORKING BOYS AND GIRLS

REGINE K. STIX, M. D., and ARTHUR LENZ

NEW YORK STATE recognizes that a boy or girl who is passing through a period of rapid growth and physiological readjustment needs special health protection when he goes to work.

Its child-labor law therefore requires, among other protections, that anyone under 18 years of age who plans to enter employment be given a physical examination before an employment certificate can be issued for him. This requirement applies not only to full-time work, which only boys and girls over 16 can legally enter (unless they are high-school graduates) but also to after-school and vacation jobs, which are permitted for children over 14.

The examination is intended, of course, to make sure that the young worker is allowed to do only work that he is physically fit to do and that will not aggravate any existing impairment of his health.

For instance, a boy may have a heart impairment, and the job that an employer has promised him will require heavy lifting. In this case the examining doctor undoubtedly will not authorize issuance of a **regular** employment certificate, for such a certificate would permit him to take that unsuitable job (if it is lawful for a boy of his age). The law, however, permits the examining physician to authorize the issuance of a **limited** certificate, which will permit the boy to do certain types of work, specified by the doctor, such as clerical work in an office.

If an applicant's condition is very severe, the doctor would refuse to authorize issuance of any employment certificate, although it is unusual for a boy or girl with a serious illness to apply for a certificate.

Although a worker under 18 for whom a regular certificate is issued, for either full-time or part-time work, must apply for a new employment certificate each time he changes his job, he is required to be reexamined by a physician only if the change occurs 6 months or more after the certificate is issued. (Before July 1947 this period was 1 year.) If the certificate is a limited one, the young worker must return for reexamination each time he changes his job; if he does not change jobs he must be reexamined at least once every 6 months.

In New York City the physical examination of applicants for employment certificates is the responsibility of the city Department of Health. (The certificate itself, which has other requirements besides physical fitness, is issued by the Board of Education.)

For many years the Health Department physicians have been giving the examinations in special "working-paper clinics," located in different parts of the city. Since 1946, in an increasing number of high schools, the department has been adding working-paper physical examinations to the other health services it gives the pupils in these schools. An advantage in this latter arrangement is that the examining physician has at hand each applicant's cumulative health record.

The Health Department directs its physicians to pay special attention to handicaps that might hinder the child in his work, and to progressive impairments that might become more serious if the young worker engaged in certain occupations. They are urged to explain to the child and his parents the reasons for postponing or limiting his employment. For example, a doctor who examines a child with sight in only one eye might well guide that child into a job that offered no hazard to his good eye, but he should also explain why he does this, and make clear how important it would be for the worker to safeguard that eye when taking jobs in the future.

On the special record form shown on page 120 of this issue of **The Child,** the examining physician notes the applicant's medical and dental impairments. If an impairment is revealed by the medical history or by the examination, the doctor may issue a limited certificate of physical fitness immediately, on the basis of his own opinion. (This certificate authorizes issuance of a limited employment certificate.) If, however, he wishes to obtain further information or advice, he refers the child to his family physician or dentist, or to a hospital clinic, requesting further information about the applicant's condition. He will tell the applicant to return to the working-paper clinic after the

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This article is based on a larger report, by Dr. Stix and Mr. Lenz, entitled "Physical Examination for Children Going to Work; an analysis of the records of 2,347 children applying for employment certificates in New York City." The report has been issued in processed form by the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C. Copies may be obtained without charge from that Bureau. The authors' judgments and recommendations are their own, and not those of the Bureau of Labor Standards or of the Children's Bureau.

needed information has been received. The doctor at the working-paper clinic then decides whether to authorize the issuing office to grant a regular employment certificate or a limited one.

He may, for certain conditions, refer the child to one of the consultation clinics of the Department of Health. At these clinics, specialists in eye, cardiac, orthopedic, and chest conditions are available, and if the applicant's impairment is within one of these fields a specialist will examine him and recommend what care he needs and what kinds of work he can undertake.

The diagnoses and recommendations, whether made at a Health Department clinic or a hospital clinic, or by the applicant's family physician, are sent to the working-paper clinic and are available when the applicant returns for reexamination.

To improve young workers' health

A few years ago the authors, under the auspices of the Health Department, made a study of a sample of the records of applicants who were given their first physical examination for an employment certificate at one of the working-paper clinics, during the period June 1, 1946, through December 31, 1947. (The records were from five of the six working-paper clinics. No applicant examined at a high school was included.) In these clinics between 80,000 and 200,000 young persons 14-17 years of age are examined each year, the number varying with labor-market conditions.

The study was planned to find out to what extent the examinations given in the working-paper clinics actually were protecting the health of the boys and girls examined. And in view of the health problems brought to light by the examinations, it was expected that the study would suggest further steps that should be taken to improve the health of young workers.

The records were analyzed with three questions in mind:

1. What sort of impairments were found and how frequently were they found?
2. What was done about these impairments?
3. How many children who had been instructed to return for reexamination after going to work returned for such examination, as the law requires?

Records of 2,347 applicants were studied, of whom 57 percent were boys. Nearly all were white. Three-fourths were at least 16 when they were examined.

For 83 percent of all the applicants studied, the doctors authorized issuance of regular employment certificates, either before or after the applicant was referred for expert opinion. Limited certificates were authorized for about 14 percent, and the remaining 2½ percent were referred for consultation, but never returned. No applicants were rejected because of impairments.

About a fifth of the applicants had at least one medical or dental impairment. (An impairment as defined for the study was a defect so serious that the doctor either authorized issuance of a limited certificate at once or referred the boy or girl for consultation.) Three hundred and eight of the applicants had medical impairments; of these 38 had dental impairments also. Two hundred and twenty had dental impairments only. The dental impairments were those sufficiently serious to be revealed in an inspection of the mouth by a physician, and to warrant immediate referral for care. It is probable that had the applicants been examined by dentists, more dental caries would have been found.

Since an applicant with extensive dental caries cannot as a rule afford good dental care, the policy was followed when possible of authorizing a limited certificate for such an applicant in order to permit him to earn the money for such care; this was done for about half of these applicants. For 17 percent regular employment certificates were authorized after the applicant had had immediate dental care. One-fourth were referred for care, and then limited certificates were authorized to allow for the completion of dental care begun at the time of referral. Nineteen applicants referred for dental care did not return to the clinic.

Until a defect in her vision is corrected, this applicant for working papers will not be certified by New York City's Health Department as physically fit to do the job she plans to enter. She is being fitted with eyeglasses at one of the Health Department's consultation clinics.

BOARD OF EDUCATION
BUREAU OF ATTENDANCE

CITY OF NEW YORK
RECORD OF PHYSICAL EXAMINATION OF CHILD
APPLYING FOR A CERTIFICATE OF PHYSICAL FITNESS

DEPARTMENT OF HEALTH
☐ 1ST EXAM. ☐ REN. REG.
☐ REN. LIM. ☐ OTHER

RESIDENCE:
FAMILY NAME OF CHILD — GIVEN NAME | HOUSE NO. | STREET | BORO | ZONE | BORN: MO. DA YR. 19

ISSUING CLINIC | SCHOOL ATTENDED | BORO | ZONE | CLASS | SEX B G | COLOR W C O

19 DATE OF EXAMINATION | FT. HEIGHT | IN. | WITHOUT OUTER CLOTHING LBS. WEIGHT | VISION: WITHOUT GLASSES / WITH GLASSES | RIGHT | LEFT | BOTH

MEDICAL HISTORY (PLEASE CHECK DISEASES APPLICANT HAS HAD AND DESCRIBE UNDER REMARKS)

☐ SCARLET FEVER ☐ HEART DISEASE ☐ PNEUMONIA ☐ DIABETES
☐ RHEUMATIC FEVER ☐ TBC. SELF ☐ TBC. CONTACT ☐ ALLERGY (Incl. Asthma) ☐ KIDNEY DISEASE
☐ CHOREA ☐ BRONCHITIS OR CHRONIC COUGH ☐ POLIOMYELITIS ☐ CONVULSIVE ATTACKS

OTHER DISEASES (LIST HERE)
HOSPITAL CARE, WITH CAUSE
FATHER ☐ LIVING ☐ DEAD (CAUSE OF DEATH) MOTHER ☐ LIVING ☐ DEAD (CAUSE OF DEATH)
REMARKS:

TYPE OF JOB ☐ F. T. ☐ P. T.

PHYSICAL EXAMINATION | HEART RATE: BEFORE EXERCISE IMMEDIATELY AFTER TWO MINUTES AFTER B. P.

CODE ITEMS BELOW AS FOLLOWS: O - NORMAL V - DEFECT (Describe All Defects Under Remarks)

1. ☐ EYES
2. ☐ EARS
3. ☐ HEARING
4. ☐ MOUTH & THROAT
5. ☐ SKIN
6. ☐ TEETH
7. ☐ NECK (INCL. GLANDS)
8. ☐ HEART
9. ☐ LUNGS
10. ☐ ABDOMEN
11. ☐ HERNIA & GENITALIA
12. ☐ ORTHOPEDIC
13. ☐ NEUROMUSCULAR (Strength, Coordination, Speech)
14. ☐ OTHER

REMARKS:

MEDICAL REFERRAL
DATE:
IF D. OF H. CONS CHECK:
☐ CARDIAC
☐ EYE
☐ ORTHOPEDIC
☐ OTHER

☐ REGULAR CERTIFICATE ☐ LIMITED CERTIFICATE ☐ PERMANENT REJECTION ☐ DECISION PENDING

DATE SIGNATURE M.D.
WORKING PAPER CLINIC
DATE SIGNATURE M.D.
FORM 941A WORKING PAPER OR CONSULTATION CLINIC

BOARD OF EDUCATION
BUREAU OF ATTENDANCE

CITY OF NEW YORK
RECORD OF PHYSICAL EXAMINATION OF CHILD
APPLYING FOR A CERTIFICATE OF PHYSICAL FITNESS

DEPARTMENT OF HEALTH
☐ 1ST EXAM. ☐ REN. REG.
☐ REN. LIM. ☐ OTHER

RESIDENCE:
FAMILY NAME OF CHILD — GIVEN NAME | HOUSE NO. | STREET | BORO | ZONE | BORN MO. DA. YR. 19

ISSUING CLINIC | SCHOOL ATTENDED | BORO | ZONE | CLASS | SEX B G | COLOR W C O

19 DATE OF EXAMINATION | FT. HEIGHT | IN. | WITHOUT OUTER CLOTHING LBS. WEIGHT | VISION: WITHOUT GLASSES / WITH GLASSES | RIGHT | LEFT | BOTH

I HEREBY CERTIFY THAT I HAVE EXAMINED THE ABOVE NAMED APPLICANT AND FIND THAT HE IS PHYSICALLY QUALIFIED FOR LAWFUL EMPLOYMENT, BEING IN SOUND HEALTH AND OF NORMAL DEVELOPMENT OR THAT HE IS IN SUCH CONDITION AS JUSTIFIES THE LIMITED EMPLOYMENT INDICATED.

A ☐ REGULAR CERTIFICATE

B ☐ LIMITED CERTIFICATE, AUTHORIZING EMPLOYMENT UNTIL
IN THE FOLLOWING OCCUPATIONS ONLY:
REASON FOR LIMITATION
NOTE CODE NO. ONLY

REMARKS:

THIS IS NOT AN EMPLOYMENT CERTIFICATE

M. D.
SIGNATURE OF EXAMINING PHYSICIAN

FORM 941-250M-3-49 33

Among the 80 children with cardiac findings, nearly all (73) were referred for consultation before any certificate was issued; regular certificates were authorized for 33 of these after consultation. It may be presumed that most of these 33 were children who had only functional murmurs. Limited certificates were authorized for 7 without referral, and for 24 after referral. Sixteen of those referred for consultation did not return.

For about a third of the 141 children with visual impairments limited certificates were authorized without referral for consultation or care. Nearly 40 percent of those referred received regular certificates following referral. It is probable that those receiving regular certificates had little or no functional impairment, once their sight was corrected by glasses. Fifteen of the children referred for consultation never returned and presumably never sought the advice of a specialist.

The remaining 87 children were found to have miscellaneous medical impairments, including orthopedic, nutritional, and skin defects. The number in each group was too small to permit detailed analysis.

Excluding the children with possible cardiac impairments, for whom special care was desirable, it was found that the examining physicians in the working-paper clinics authorized limited certificates for somewhat less than a third of the children with medical problems. In these cases the physician apparently felt that he had gained sufficient information through the examination and the history to be able to make his decision without additional tests or consultation.

Of the 155 applicants with medical impairments who were referred to other clinics or to family doctors 24 failed to return. Of those who did return, however, regular certificates were authorized for nearly half. It thus appears that when an impairment was found or suspected the clinic physcians may have been more cautious than was necessary. It may have been, of course, that the child had received immediate

medical attention which took care of the impairment.

The tendency of clinic physicians to be cautious when they suspect an impairment has been observed repeatedly by one of the authors, who was formerly in charge of the service. The doctor may feel that he is protecting himself from possible legal action in case the child's condition should become worse while he was working in an unrestricted occupation.

For a child who needs to have full confidence in his ability to do what others do, however, this can be very harmful. It may be that additional training of clinic physicians in diagnostic procedures would help to reduce the number of unnecessary referrals for consultation. Possibly also this would mean less unnecessary limitation of the activity of young workers.

As was previously stated, the examining physicians found it desirable to refer many applicants with apparent medical problems to their family physicians, or to a public-health or other clinic for consultation or advice. After referral, however, 18 percent failed to return to the working-paper clinic. Probably some of them went back to school rather than make the effort to seek further medical advice, and some may have worked without employment certificates. Others presumably waited until they were old enough to work without an employment certificate and without going to a doctor.

Before and during the period covered by this study, there was no routine follow-up of children who did not return after medical referral. Since 1948, however, children applying for full-time work who have been referred for consultation and who have not returned have been followed routinely by the city Board of Education's Bureau of Attendance. The attendance officers find that most of these children return to school rather than go for additional medical advice. If the child is not in school, the attendance officer has usually been able to persuade him to go for the medical consultation necessary for the issuance of an employment certificate. If the child is still going to school the information regarding the medical findings is sent to the school public-health nurse for follow-up. If the condition is potentially serious, and the child has left school, the public-health nurse in the district where he lives visits his home to see that he receives adequate medical care.

Examination has a public-health function

This follow-up procedure is an important advance in policy, for if a medical problem is found but not followed up, the examination of the child has failed partly to fulfill its function. The purpose of a medical examination of a child about to go to work has two aspects. It is (1) a method of making sure that the child will not be employed in an occupation harmful to him and (2) a public-health case-finding procedure that will serve to find the child with impairments who needs medical care. It is useless to find a child who needs medical care if he fails to receive that care.

For this reason special emphasis has been placed on the follow-up of children with medical problems. Authorizing issuance of a limited certificate gives the clinic physician a good opportunity to follow up the child in need of medical care who returns for reexamination. It is important also to make some provision for finding and following the child who fails to return after the medical referral, to see that he too receives whatever medical care he needs.

Follow-up is needed also when a limited certificate has already been issued. Such a certificate was authorized for 14 percent of the applicants studied. To be legally employed they should have returned for reexamination whenever they changed jobs, or at least every 6 months. On the basis of a sample of cases in one clinic, where this information was available, only 35 out of the 55 children for whom limited certificates were issued ever returned for reexamination.

The purpose of the requirement that a boy or girl with a physical defect return for reexamination on each change of job, or at least every 6 months, is to permit the doctor to find out how the young worker's duties are affecting his health, and whether he is receiving adequate medical care.

In a special study of minors working under limited certificates the New York State Department of Labor followed up 159 children so employed, and found that one-fifth of them were working in occupations other than the one described on the pledge of employment for which the certificate had been given.

At present there is no way of checking routinely on the suitability of the work being done by children with limited certificates unless they return for reexamination. It is obvious that better provision should be made for the follow-up of these children to see that they do return.

Of 412 young workers who had been working under regular employment certificates and who returned for reexamination, nine-tenths were again granted regular certificates. Nineteen were denied the regular certificate in order to insure their obtaining dental care and were recommended for limited certificates. Twenty-two had medical impairments, and all were recommended for limited certificates. Only 7 of these were referred for consultation; of the 15 not referred, 13 had visual defects and 2 had presumptive cardiac findings.

Some of these medical problems, including those of the seven children referred for consultation, were apparently newly discovered on reexamination. However, one must question the judgment of the clinic physicians who authorized limited certificates for children previously given regular certificates on the advice of specialists. If a child's condition seemed to have changed he should have been referred for consultation again at the time of reexamination. The data are insufficient for a valid conclusion, but they suggest that some physicians in the working-paper clinics may have been overcautious in authorizing limited certificates and at the same time somewhat careless in not referring children for

additional consultation when indicated.

For 102 out of 138 boys and girls who had been working under limited certificates and who returned for reexamination, limited certificates were again authorized. But regular certificates were authorized for 36 without referral; 15 of these had medical impairments; 21 had only dental ones. For 2 of the 15 children with medical problems their original limited certificates had been issued on the recommendation of a cardiologist. It is possible that two doctors examining a child at different times could disagree on findings, but it is difficult to understand why a physician should, without consultation, authorize issuance of a regular certificate for a child for whom a limited certificate had been recommended previously by a cardiologist.

Health record important

The failure to refer children for consultation when it is indicated, or to follow the previous recommendations of the consultant if there is no change in the child's condition on reexamination, raises a serious problem. The numbers involved are small in this sample, but they point to the possibility of other similar errors on first examination which would not be apparent in the data available for this study.

It is true that the atmosphere of a busy clinic, especially in the rush of summer applications for employment certificates, is not one that encourages deliberate, thoughtful medical histories and examination. No cumulative health record is available in the clinic, and the young person is anxious only to get his papers so that he can work. It would seem that a much better service for the applicant could be available in his own school, where the school physician has each applicant's cumulative health record and where he is not so pressed for time. Experience in high schools in which examinations for employment certificates are part of the regular health service shows this to be true.

An analysis, for this sample (1946-47), of returns for reexamination as compared with returns for the whole city in 1948 and 1949, reveals a change in pattern brought about by a revision of the law in 1947. The revision reduced from a year to 6 months the period after which the child for whom a regular certificate is issued must return for reexamination if he changes his job. No change was made with regard to limited certificates.

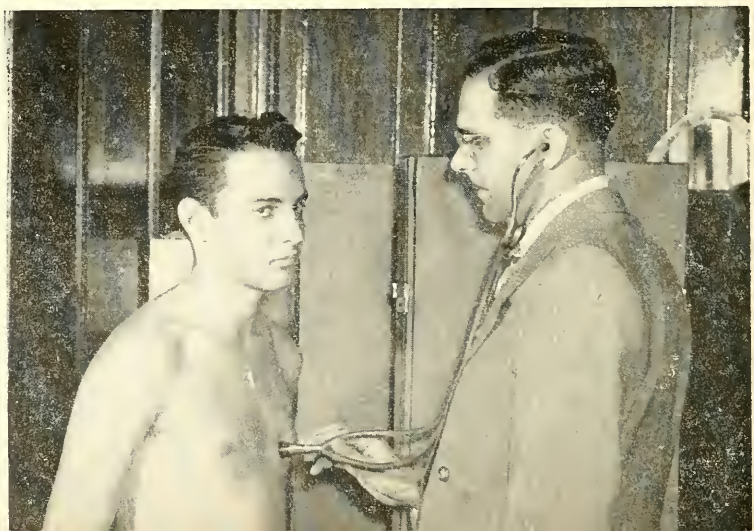
In 1948 and 1949, when children working under regular certificates were required to return for reexamination if they changed jobs 6 months or more after the original examination, the proportion of children returning for renewal of their certificates was approximately double that in 1946 and 1947. This increase places an additional burden on the clinic physicians as well as on the staff of the Bureau of Attendance of the Board of Education—a burden which, however, does not appear to contribute substantially to the health of the children involved. If the findings of this small sample are valid it may be assumed that about 5 percent of these children might have had new medical impairments, but there appears no reason to believe that a 6 months' delay in examination would have been a serious hazard to them.

Recommendations

1. Although the available data are limited, they suggest that examination of the applicant in his school, with his health records at hand, would probably lead to fewer errors in judgment on the part of examining physicians. With the extension of Department of Health services to all senior high schools and an increase in such services in junior high schools, it should be possible to eliminate working-paper clinics for all children in public schools in New York City.

2. In our opinion a revision of the law to require less frequent reexamination of children in good health would enable the staff of both the Department of Health and the Board of Education to give more attention to those with medical problems. For example, an annual examination of all children with regular certificates, regardless of change of job, would assure all children some follow-up. The present provisions of the law concerning children working under limited certificates appear to be adequate, but more emphasis should be placed on seeing that **all** these children are followed up to be sure that they receive adequate medical care and proper job-placement services. Current thinking in public health is directed toward finding medical problems and arranging for the adequate care and supervision of the individual. Applying this philosophy to the administration of our child-labor law would probably lead to more effective protection of the health of the working child.

Any findings that seem to show an abnormal heart condition must be carefully interpreted before a recommendation is made concerning the kinds of work the applicant can do safely.



LET'S JOIN HANDS FOR THE GOOD OF CHILDREN

Children's workers in different professions can meet on common ground

SAMUEL M. WISHIK, M. D.

THOSE OF US who are working with children represent many different professions—medicine, education, psychology, social work, nutrition, nursing, nursery education, to name a few. If a good job is to be done for children, no longer can any one of these professions plan or do its work alone. Each profession must draw upon the knowledge and skills of the others.

Such mutual planning and activity can occur: (1) Among the professions, (2) among agencies, and (3) among individuals. Certain principles, which apply, more or less, without regard to the specific profession concerned, can be defined to guide these relationships.

Professions need each other's help

To promote professional interaction, a minimum core of knowledge should be held by all persons working with children and youth, regardless of specialty. For example, they certainly should be expected to know something about the personality of children—and of adults—and something about the development of personality during the growing years.

Unfortunately, the need for common knowledge and skills is not sufficiently recognized in professional schools. Schools of social work usually require but one elementary course in medical background. Some teacher-training institutions hardly touch upon the growth and development of the normal child. Medical schools should teach more about the social and cultural aspects of health and sickness—for example, family relationships, housing conditions, and dietary practices among certain ethnic groups.

Each profession should, when necessary, leave its traditional sphere and borrow from any profession that can contribute to it. Our present concepts of personality growth have been developed not merely by the fields of pediatrics, social work, psychiatry, and education, but also by the contributions of psychology, sociology, and anthropology.

In addition to a common core of knowledge, people working with children also need to acquire a common set of skills. At least they should have enough skill in dealing with people to permit their professional work to be effective. One skill that we all need, but which is taught in few medical or nursing schools, is interviewing, although we could gain much by borrowing its techniques from the profession of social work. Neither a physician nor a nurse should attempt to be a case worker. On the contrary, it is essential that they recognize their lack of such qualification. They should, however, be sensitive to people, be able to understand their reactions, to pick up leads dropped unintentionally, and to permit flexibility in the progress of the interview.

Lack of understanding of the techniques of interviewing may make us largely ineffective, and we may actually distress the very people we are trying to help.

For example, recently, when a mother asked the pediatrician in a child-health conference about a spot on her baby's cheek, he said merely, "It's nothing." The doctor knew that the spot was unimportant and that it would be gone in a day or two. But a few moments later, this mother, while talking with the nurse, burst into tears and said that she was worried about the spot. When the nurse asked whether she had spoken to the doctor about the spot, the mother sobbed, "Yes, I did. But he is not interested. And I'm afraid that spot is something serious."

In another child-health center, not long ago, a young mother and father came in with their little baby and the grandmother. When the doctor asked, "How's the baby?" the grandmother said the baby was "jumpy." The physician ignored the answer and began to discuss the general care of the baby. Later, it was learned that the baby's father had epilepsy and that the grandmother had not wanted him to get married and have children. The entire family was tensely waiting for the baby to have his first fit.

Now this pediatrician had disregarded the statement that the baby was jumpy because he knew that 2-month old babies normally have a strong startle reflex, and he assumed that was what concerned the grandmother. He was not sensitive enough to detect that there might be a less routine factor in this particular instance.

We must take a broader view

We in medicine and nursing tend to decide whether or not a problem

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Skill in interviewing is a valuable asset to a public-health nurse in contacts with families.

is important in strictly medical terms and not according to the importance of the problem to the person who poses it. What may seem silly from our point of view may be of very great importance to a mother and deserves a careful answer appropriate to her interest.

In an interview, a doctor or nurse often has a certain amount of material that needs to be covered. If skilled in interviewing, however, the worker may temporarily give up the plan to include all the instructions on the list. For if the mother is encouraged to express what she has on her mind, an unexpected opportunity may arise to help her develop an attitude that may benefit the child far more than the planned information.

Another skill that physicians and nurses would do well to acquire is in the technique of guiding group discussions. Of particular value as an adjunct to the usual child-health conference routine, the group discussion has three main values: It facilitates changes in the attitudes of parents, in the attitudes of the staff, and in the focus of the child-health conference.

In the usual interview between doctor and mother, or nurse and mother, the mother asks a few questions and does most of the listening. The content of these interviews is usually limited to the feeding and general child care. In group discussion, however, the mothers do most of the talking and the doctor or nurse does more of the listening. The professional workers learn what the mothers really think and what bothers them most. Stimulated by cross-discussion with other mothers facing similar problems, the mothers are able to talk freely. They are comforted by learning that other mothers have similar problems. And while realizing that every baby is different, each mother is helped to acquire a flexible attitude toward her own child.

Leading a group discussion admittedly requires a skill that is learned through a type of training most doctors and nurses do not have. It is obviously not done by the lecture method.

For more effective research

Besides borrowing special work skills, the medical, public health, and allied professions can find value in other professions' methods of study and research. Medical research is usually concerned with direct cause-and-effect relationships—what causes a disease, what medicine will cure it. Such disciplines as sociology and psychology have developed investigating techniques that may be adapted so as to be used in evaluating programs, in discovering why parents act as they do toward their children, or in finding out why certain methods do not succeed in changing parents' attitudes and practices in child rearing.

Professional people need to take the initiative in lending as well as in borrowing. For example, the modern public-health nurse working in a school should make every effort to inform the teacher about the health needs and problems of the school-age child. The effective social worker uses each case discussion not only to benefit the child but also to pass along to the other professional workers information and principles that may be useful in meeting the needs of other children in the future.

Professional people need to know about the kinds of special knowledge and skills peculiar to the various specialties dealing with children. Each profession has its own unique contribution, which reaches greater effectiveness when it is fully understood by the other professions. More and more schools of nursing, for example, are giving their students experience in nursery schools, not only so that they can learn to understand little children, but also to observe the methods of nursery educators.

Unfortunately, each profession has developed a language all its own. Even the most intelligent person can be quickly lost in the maze of technical language so familiar to the doctor, or the nurse, or the social worker. As professional people we must make a constant effort to eliminate "jargon" when communicating with anyone outside our immediate group.

If a physician wants to have the school program of a handicapped child changed, he tells the teacher very little when he gives a technical diagnosis of the child's heart condition. Nor does the teacher tell the doctor anything he can understand when she says that the school provides "adaptive physical education." Instead, the physician should state

specifically the kinds and amounts of physical activities the child may not carry on—climbing stairs, dancing, playing baseball, doing setting-up exercises. And the teacher should describe the school program in terms of exactly what physical demands are made upon the children. The doctor and the teacher would then be talking the same language.

To improve the relationships among the professions, then, certain steps must be taken. Changes need to be made in the present methods and content of professional education, both in schools and in post-graduate or in-service training. A minimum common core of knowledge about children should be taught all persons who expect to work with them. A minimum common set of skills must be acquired by these various specialists. They should borrow freely from, and lend to, each other, while nonetheless recognizing the unique function and contribution of each. Finally, terminology should be kept simple, and understandable to the uninitiated.

Agencies can work together

It is easy to agree that agencies should **plan** together, but not always easy to know just how. For example, planning to meet a community's needs for hospital facilities for children might seem to require only the work of the medical profession. Yet children cannot be treated properly without provision for a number of services, such as convalescent care, including the use of foster homes. So social workers are needed to help in planning the program. Children who are in hospitals for long periods often are able to continue their education, and many need to have some kind of recreation adapted to their needs. So teachers (including nursery-school teachers), recreation workers, and social group workers should also be included in the plans.

Agencies can also cooperate in the **operation** of programs. For example, child-welfare agencies call on health departments for medical services to their clients. (And, incidentally, health departments might cooperate more in social-service exchanges than they do now.) In some communities a step toward teamwork is taken when all agencies agree to use the same type of referral form.

In order that agencies may work together well, their various jurisdictions and areas of interest must be defined. To avoid duplication is only one reason for this; equally important is to avoid omitting necessary services. For example, although children's institutions properly belong under the welfare department, yet the health of these children must be protected; and the health department should contribute to such protection through participation in a program of supervision and consultation. In such a program confusion can be prevented through joint planning and cooperative procedure.

For teamwork among individual workers

As individuals working with children we can do much to improve the mutual planning and activity of our profession. We must know the resources in our communities for other professional services and the most effective ways of referring children to these services. Private physicians are relatively uninformed about community resources and may spend a lot of time before their patients finally are referred to the most appropriate agency. Social agencies and other professional groups should make every effort to inform physicians about community services.

Professional people can participate on advisory committees for agencies in other fields to help in exchanging points of view. Obviously, the staffs of agencies should learn the value of appointing representatives of various professions to their advisory groups and committees. Of course there must be a balance between committees that include members of other professions and those that are so specialized that only one or two professions are included.

A good thing can be carried too far

Teamwork among the various professions, particularly when they are all represented in a single agency, is, of course, very valuable. Sometimes, however, such teamwork is distorted by inappropriate procedures. A program may be nullified by too much attempt at teamwork, if no staff member dares to move without first clearing with all the others. Although such clear-

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A question that seems slight to the doctor may be of great importance to an anxious mother.

HOSPITALIZED CHILDREN

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the social relations into which they thrust him.

If we can look ahead to a time when such social group-work services have proved themselves in a sufficient number of places, it is conceivable that the group worker might make a further contribution to the life of the hospital as a whole. The hospital, like the summer camp and the institution for children, offers the child a group-living situation. Although the factor of illness and the requirements of medical treatment make hospital conditions different from most other group-life conditions, many of the basic aspects of hospital life are not unlike those in other institutional frameworks.

Some hospital administrators, in fact, realize that the hospital has group aspects of its own. At a recent meeting of the American Hospital Association one session was devoted to theories of group organization and supervision. It was evident at the meeting that the current interest in the dynamics of the group process, an interest that is evident in education, in personnel management, and elsewhere, had influenced the hospital administrators. If the hospital as a community with a social structure becomes better understood, this will lead inevitably to a realization of the group factors in that community's life. From our present observation of such hospital communities, it is clear that certain group and intergroup relations are of major importance in establishing the social climate in which hospitalized children live.

One of the most important intergroup factors is the relation between various hospital personnel—the administrators, doctors, nurses, therapists of various kinds, social-service workers, and maintenance and service workers. Although these are in one sense personal relations, they also have an important intergroup aspect in terms of the jurisdiction of each and the feeling tones of rivalry or of helpfulness that exist between them. If the social group worker is a member of the social-service staff, as we think he should be, he will contribute to better integration and more mutual helpfulness between the staff groups.

If a group worker is to be equipped to fulfill the functions described here, what kind of training does he require? So far only a few schools of social work are attempting to train group workers especially equipped to work in hospitals. In the writers' opinion, the best training results when a student has a basic first year of social work, including a field placement involving contacts with groups of children. This might be in a settlement house, a children's institution, or some similar situation.

If, at the end of the first year, or the first half of the course, the student is interested in social group work in hospitals, he should take, in addition to the required group-work sequence, courses that will provide the necessary specifics related to the setting, and he should have his field practice in a hospital or a clinic. The courses would include a course in group work in therapeutic settings and additional courses in psychiatry, medical information, and public health. Most important of all, his field experience must enable him not only to adapt his recreation skills and understanding of group work to a hospital setting, but also to fit into a medical team easily and fruitfully. He will need to learn, that is, how to function as a member of the social-service department in a hospital.

Although experience is still too limited to claim substantial results, we believe that the addition of a social group worker to the therapeutic team in a children's hospital will, as time goes on, prove to be a significant new step in the team's efforts to help hospitalized children have a more normal and happy childhood. We believe that it will be a real assistance to children in their struggle to recover.

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ance is very appropriate at a planning stage it is less so during the operation of a program.

The effective specialist works within his own particular area, but makes it his business to find out enough about the other specialties so that he knows when to call for consultation or to refer the client to some one else. He becomes sensitive to aspects of problems not usually part of his domain.

Close association of individuals from different professional backgrounds should result in their mutual education to the point where each can do his own work more effectively and with a broader approach and can be more sensitive on a selective basis to indications for calling upon the other in consultation, or for referral to the other to take over.

For example, a social worker in a health department will consider that she is doing a successful job when the staff calls upon her less frequently but more selectively, and when she sees that the staff recognizes the social aspects of health care in the services they are giving. When other members of the staff become aware of these social aspects she has a measurement of her own effectiveness and theirs.

We are living in an age of specialization that is good and necessary. Each specialist must be well-grounded in his own discipline. Each specialist must recognize that he exists in a society of other specialists with whom he must work. A pediatrician who does not know about the psychological motivations of parents and a psychiatrist ignorant of normal children are equally ineffective in helping the mother whose child seems to have a feeding problem.

Most of our professions, even the traditional ones, are still rather young, and with youth should retain the flexibility that they need to keep in step with a rapidly changing world.

IN THE NEWS

AIIPC. Martha M. Eliot, M.D., Chief of the Children's Bureau, has been appointed by President Truman as U. S. technical delegate on the Directing Council of the American International Institute for the Protection of Childhood. Elisabeth Shirley Enochs, Chief, International Technical Missions, Office of the Commissioner for Social Security, Federal Security Agency, has been named alternate U. S. technical delegate. Both appointments are for 3-year terms.

Formally established in 1927, the American International Institute for the Protection of Childhood is an intergovernmental body which serves as a center of action, information, advice, documentation, and study on all questions relating to child life and welfare in the Americas. The Institute conducts bibliographical research, collects information by correspondence, and, on the request of member states (the 21 American Republics) undertakes field studies and gives advisory service. United States participation in the Institute was authorized by an act of Congress, approved May 3, 1928. Meetings of the Directing Council, which serves as the governing body of the Institute, are held annually at Montevideo, Uruguay. The last session was held November 30-December 1, 1951.

Juvenile delinquency. Upward trends are becoming pronounced in the number of delinquents coming to the attention of juvenile courts and in the number of children who have been arrested by police.

The upswing began in 1949, a year of international unrest, and continued in 1950, the year in which active conflict broke out in Korea.

In 1949, juvenile-court delinquency cases showed an increase of 4 percent over 1948, reversing a downward trend noted each year since the end of World War II. In 1950 the upswing continued, the number showing another 4 percent increase.

An independent series of data, based on police arrests of children under 18 years of age whose fingerprint records were transmitted to the Federal Bureau of Investigation, showed a similar disturbing increase of 4 percent in 1949 over 1948. This increase also reversed the downward trend noted in those data since the end of World War II. In 1950 the increase continued (by 5 percent over 1949), and, in the first 6 months of 1951, police arrests of children were already 9 percent higher than in the first 6 months of 1950.

The figures showing the trend in number of delinquency cases are based on reports from 211 of the more than 400 juvenile courts that report to the Children's Bureau. (The 211 courts form a comparable group for statistical purposes, as their data are available for each of the years 1946-50.) It is estimated that the full annual count of delinquents coming to the attention of all the juvenile courts in the United States is approximately 300,000—4 boys to every girl—and that the annual number apprehended by the police is much greater than that.

Data compiled by the Federal Bureau of Prisons on offenders under 18 charged with violation of Federal laws show also that the trend downward which had continued since 1946 has stopped. There were 1,999 cases of such offenders disposed of by Federal courts in fiscal year 1950 as compared with 1,812 in 1949. The fiscal year 1951 showed 2,130 cases disposed of, a continuation of the upward trend.

Indonesia. Approximately 16,000 Indonesian school children are now receiving a daily ration of skim milk and cod-liver-oil supplied by the United Nations International Children's Emergency Fund (UNICEF).

UNICEF aid in Indonesia also includes supplies for a program to combat yaws, assistance in maternal and child-health services, and fellowships.

Mental Health of the Child in Conflict With the Law will be discussed by one section of a mental-health workshop to be held at this year's convention of the International Council for Exceptional Children. The convention, which is the thirtieth annual meeting of the Council, will be held at Omaha, Nebr., April 30-May 3.

To Our Readers—

We welcome comments and suggestions about **The Child.**

CALENDAR

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May 23-25. Young Men's Christian Associations, National Council. Annual meeting. Detroit, Mich.

May 25-30. National Conference of Social Work. Seventy-ninth annual meeting. Chicago, Ill.

Some other organizations meeting in association with the National Conference of Social Work:

American Association of Group Workers.

American Association of Medical Social Workers.

American Association of Psychiatric Social Workers.

American Association of Social Workers.

Association for the Study of Community Organization.

Big Brothers of America.

Child Welfare League of America.

Florence Crittenton Homes Association.

Medical Social Consultants in State and Local MCH and CC Programs (May 24-25).

National Association of School Social Workers.

National Association of Training Schools.

National Child Labor Committee.

National Committee on Services to Unmarried Parents.

National Probation and Parole Association.

National Publicity Council for Health and Welfare Services.

May 26-28. National Council of Juvenile Court Judges. Fifteenth annual conference. Indianapolis, Ind.

May 26-29. National Tuberculosis Association. Forty-eighth annual meeting. Boston, Mass.

May 27-31. American Association on Mental Deficiency. Seventy-sixth annual meeting. Philadelphia, Pa.

May 28. Young Women's Christian Association. Forty-fifth annual meeting of the National Board. New York, N. Y.

Illustrations:

Cover and pages 115, 116, and 125, Esther Bubley for Children's Bureau.

Pages 119 and 122, New York City Department of Health.

Page 124, Arch Hardy for Children's Bureau.

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

• CALENDAR

May 1. Child Health Day.

May 1-7. Correct Posture Week. Sponsored by the National Chiropractic Association.

May 2-3. American Council on Education. Thirty-fifth annual meeting. Chicago, Ill.

May 4-8. Boys' Clubs of America. Forty-sixth annual meeting. Columbus, Ohio.

May 4-9. Camp Fire Girls Triennial Conference. New York, N.Y.

May 4-10. National Hearing Week. Twenty-fourth annual observance. Information from the American Hearing Society, 817 Fourteenth Street, N.W., Washington 5, D.C.

May 4-10. National Mental Health Week. Information from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

May 4-11. National Family Week. Tenth annual observance, by Protestant, Catholic, and Jewish groups. Information from the National Council of the Churches of Christ, 79 East Adams Street, Chicago 3, Ill.

May 5-6. Society for Pediatric Research. Twenty-second annual meeting. Old Point Comfort, Va.

May 7-9. American Pediatric Society. Sixty-second annual meeting. Old Point Comfort, Va.

May 8-9. National Midcentury Committee on Children and Youth. New York, N. Y.

May 8-11. American Psychoanalytic Association. Annual meeting. Atlantic City, N. J.

May 12-17. General Federation of Women's Clubs. Sixty-first annual convention. Minneapolis, Minn.

May 19-21. National Congress of Parents and Teachers. Fifty-sixth annual convention. Indianapolis, Ind.

May 22-25. National Federation of Settlements and Neighborhood Centers. Thirty-seventh annual conference. Milwaukee, Wis.

May 23-24. Boy Scouts of America. Forty-second annual meeting of the National Council. New York. N. Y.

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U. S. GOVERNMENT PRINTING OFFICE 1952-952603

THE CHILD

MAY
1952

Citizens Urged to Make May 1 Friendship Day for Crippled Children Throughout Nation

Martha M. Eliot, M.D.
Chief, Children's Bureau

Child Health Day in 1952 gives us a chance to see how we can make every day of the year friendship day for handicapped children.

Ever since 1928, when both Houses of Congress, by joint resolution, authorized and requested the President to designate May 1 as Child Health Day, citizens, with the guidance and help of State health departments and State crippled children's agencies, have used this day as the starting line for action to build better health for one group of children or another.

One year Child Health Day was the start of a drive to make sure children were immunized against certain contagious diseases. In another year, citizens worked to prevent accidents, which kill more children than any single disease.

This year, the Children's Bureau has proposed that Child Health Day be the day on which we focus our attention on the many thousands of children in our country who have handicapping conditions.

No one has an accurate count of the total number of such children. But there is probably no adult who does not know of some child struggling with a physical, emotional, or mental disability, who could be helped to live a more satisfying and self-sustaining life.

Through our great variety of voluntary organizations, and our small but soundly built public services, we already are transforming the lives of hundreds of thousands of youngsters who have some kind of physical or mental strike against them. But no one can claim that, as a Nation, we are doing all that can be done for handicapped children.

Few of us have enough professional skill as doctors, nurses, psychologists, teachers, and the scores of other professions that work with children to give them technical help.

But certainly we all have one skill we could and should be putting to use for them: The skill of making friends.

For handicapped children want to belong as much as other children do. They want the chance to develop their own initiative, their own friendships and loyalties, their own integrity.

The degree to which any handicapped child can make progress, naturally depends on the disability he has; some crippled children obviously can achieve less than others.

But many more handicapped children could be helped to a happier and more useful life if more of us included more of them in our work and play and in our normal community life.

On Child Health Day 1952 many groups of citizens will be meeting to plan child-health projects. Let's bring the handicapped child out of his isolation and make him one of us.

State Programs Aid Many Thousands of Handicapped Boys and Girls

Arthur J. Lesser, M.D.
Director, Division of Health Services, Children's Bureau

The Nation is making slow but sure progress in its programs for crippled children as more States extend their services to reach children with crippling conditions.

It was not until 1897 that any State passed a law to aid crippled children. Now all States have programs that provide care for at least a limited number of boys and girls under 21 years of age who have a handicap that needs orthopedic or plastic treatment. This means children with hare lip, or cleft palate, or club foot; children with deformed bones; children who have been seriously burned, or otherwise badly hurt in an accident.

About half the States also include in their programs children with rheumatic fever and cardiac conditions. An increasing number are developing services for children with cerebral palsy and those with epilepsy and for children with visual or hearing handicaps.

There is a clear trend toward inclusion of more types of handicapping conditions in State crippled children's programs.

More children now receive care under State crippled children's pro-

grams than in any year since the programs started.

During 1950, approximately 215,000 children received diagnostic or treatment services from doctors, in clinics, hospitals, or convalescent homes, or through office or home visits. This was an increase of 35,000—18 percent—over the number of children who received such care in 1949.

In addition to the care given by physicians, many children also are served by public-health nurses, medical social workers, nutritionists, physical therapists, occupational and speech therapists, and other medical personnel making up the rounded team of a crippled children's program.

State agencies, in offering these programs, receive financial help from the Federal Government through grants administered by the Children's Bureau.

When the Social Security Act was first passed, the amount of Federal grants authorized to help States in their crippled children's programs totaled $2,850,000 annually. In 1939, it was increased to $3,750,000, in 1946 to $7,500,000, and in 1950 to $15,000,000 for each year after 1951.

From the first full year following the original enactment of the Social Security Act until the fiscal year 1951, the full amount of funds authorized by Congress was appropriated each year. In 1951, the total authorized for the first year after the 1950 amendments was $12,000,000, and the amount appropriated was $9,975,000. For 1952 the crippled children's grants total $11,385,500.

The State crippled children's programs are important not only for the care that they provide for children, but also because of the graduate training for professional workers made possible by these funds.

CHILD HEALTH DAY, 1952

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day; and

WHEREAS the promotion of conditions that make for sound health for the Nation's children should be of vital concern to all Americans; and

WHEREAS it is fitting that we set aside a day each year for special consideration of means for the improvement of the health and well-being of our children:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate the first day of May, 1952, as Child Health Day; and I invite all agencies and organizations interested in the well-being of children to unite upon that day in celebrating the past year's gains in the health of children and in considering how programs for the protection and development of the health of the rising generation may be further advanced.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this fifth day of April in the year of our Lord nineteen hundred and fifty-two, and of the Independence of the United States of America the one hundred and seventy-sixth.

Harry Truman

By the President:

Dean Acheson

Secretary of State

FOR THE MENTAL HEALTH OF CHILDREN IN OUR SMALLER COMMUNITIES

TO GET STARTED—

Community action grows from community interest. Here are some ways of bringing mental health to the attention of professional and lay people:

Speakers and discussions in meetings of professional societies, civic and service clubs, church groups

Mental health workshops
Radio scripts
Plays designed for amateur presentation
Mental health films

For sources where material and program assistance may be had, get in touch with your State mental health agency.

R. H. Felix, M. D.

APPROXIMATELY three-fourths of American children live in cities and towns under 100,000 population. About a third of these live in rural areas, where we know that specialized health services are less accessible for these children than for the children of big cities. And probably in no health area is this inequality more striking than in mental health services.

This situation is changing. True, we still have a drastic shortage of mental health specialists. Mental health concepts are still relatively unfamiliar, even to some teachers, physicians, nurses, and other professionals who work with children and parents. Nevertheless, in spite of these and other practical obstacles, communities of all sizes and types throughout the country are beginning to build effective mental health programs for their children.

Of the need for such mental health services there is ample evidence. The roots of adult disorders are often found in infancy and childhood experiences. Many types of mental and emotional illnesses first appear or show forewarning signs during the early years of life; prompt attention may stop progress of the disease and restore mental health. Many problems of child development are so common that they are almost "normal" problems; these often can be relieved or eliminated when parents and teachers can obtain adequate guidance. Finally, psychiatrists hold that measures designed to foster a high degree of resistance to mental and emotional difficulties, and to increase mental health, are most effective when applied during childhood.

To give children this kind of help, many communities have established child guidance clinics. These services are staffed by psychiatrists, clinical psychologists, and psychiatric social workers, to provide diagnosis and treatment, or appropriate referral.

Although such clinics are still too few to meet active demands, expansion is limited by (1) a severe shortage of mental health workers and (2) expense. Furthermore, many communities realize that establishment of such a clinic is not the only measure by which a community can help its children toward mental health, nor is it always the most desirable first step in that direction.

DR. ROBERT H. FELIX is Director of the National Institute of Mental Health, Public Health Service, Federal Security Agency.

Dr. Felix was graduated from the Medical School of the University of Colorado, and did graduate work at the Johns Hopkins University. He has been awarded fellowships from the Commonwealth Fund and the Rockefeller Foundation for advanced studies. In the Public Health Service he has been senior medical officer of the U. S. Coast Guard Academy in New London, Conn.; executive officer of the U. S. Public Health Service Hospital for drug addicts in Lexington, Ky.; and clinical director of the Federal Medical Center at Springfield, Mo.

A Pennsylvania judge with a deep and active interest in juvenile mental health problems recently said: "We thought that as soon as we got our mental-health clinic here all our problems would be solved. Now I can see perfectly well how a bad school situation or an ineffective child care service could turn out more problem children on a mass-production basis than any single clinic could ever hope to serve." In many communities, both laymen and professionals are finding that a clinic may be used as a community dump for problems that should and could have been forestalled by better handling a long way back.

The National Institute of Mental Health believes that mental health clinic services are essential to a complete child health program. Through a team approach, the clinic does a job that no other agency in the community can do. The clinic's own team—psychiatrist, psychologist, psychiatric social worker, and nurse—is particularly equipped to meet the needs for specialized services.

Need wider knowledge of mental health

The National Institute of Mental Health also believes that, when a community plans a mental health program for its children, it should not think in terms of clinics alone. Numerous common "subclinical" difficulties often can be handled by parents, teachers, physicians, public health nurses, social workers, and other local people — if these individuals have a basic understanding of mental health concepts. Furthermore, a complete mental health program aims beyond a case-by-case approach. As we see it, the program can help develop many activities within the community that foster healthy child development.

The first step in mental health planning is to find out what kinds of difficulties the children have: Which children have them? Who is affected by them? Who is now dealing with them? How?

School teachers offer us many examples: The children who are intellectually normal, or even superior, yet keep failing to pass; the "bad" boys who continually disrupt the class; the quiet little girls who are apathetic toward both studies and play; the child the whole class is always picking on. Teachers can be aware that these are children who have problems. They may perceive the roots of these problems in inadequate or broken homes; in physical handicaps, or in other situations demanding special handling. In many cases, the causes will be less evident and some will remain obscure even to psychiatric study. In any case, although lacking training and time, a teacher may see clearly that a problem exists and start the wheels rolling toward securing needed help.

The courts also see mental health problems among minors who are brought in for law violations. Even knowing that juvenile offenders need understanding and wise handling rather than punishment, judges often have only two alternatives — probation or commitment of the child to an institution. In a great many cases, neither alternative is a constructive course.

Physicians are often called upon to deal with mental and emotional disorders. Frequently they detect these problems as components of the physical illnesses they treat. Through both undergraduate medical training and postgraduate education, physicians are becoming more familiar with psychiatric methods and mental health concepts. Nevertheless, a certain proportion of their cases will need special help.

Through friendly talk and observation, a psychiatrist gains insight into the child's problems.

Social case workers, too, see how emotional difficulties cause family and individual troubles, particularly how family conditions react upon growing children. The case worker dealing with children is in an especially strategic position to detect difficulties and help in their solution. Nurses and physicians in well-baby clinics and school health services have excellent opportunities to notice the early appearance of mental health problems. Clergymen are very frequently consulted on child-behavior problems, and, according to a recent National Institute of

Mental Health survey in one city, would be consulted in preference to a physician by many who have child behavior or marital problems. Lawyers find that many cases hinge upon mental and emotional factors. In short, members of every profession that deals with people will inevitably run into mental health problems, deal with them in some fashion, and, at some point, will probably need specialized help.

How can a smaller community get this help for its children?

As the program grows

A certain number of children present problems that call for intensive diagnostic study. The smaller community in some cases can make arrangements to secure clinic services from a traveling clinic team, either from a nearby university or the State mental health agency. In some instances the community can arrange to send children to a nearby guidance clinic upon referral by a physician or by an agency. There are advantages in having one community agency responsible for clinic referrals. A central file can be maintained in which individual records are kept on each child, accessible to all agencies that may be involved. Special personnel — a psychiatric social worker or a public health nurse — might help the referring physician or agency by working up the background data for the clinic and acting as liaison in the follow-up. Furthermore, such a regular connection with the clinic helps to develop a basis for further cooperation as the community program grows.

Social case worker a key person

The work of a psychiatric clinic does not end with diagnosis. Some children will need the kind of treatment that only the clinic can give; some will even need institutional treatment. But most cases, it is found, can be greatly helped by parents, teachers, and others if the clinic staff can help them comprehend the child's problems and needs. The social case worker in the community becomes a vital link between the clinic and community, helping to interpret clinic findings and recommendations, consulting with the clinic on new problems that may arise, and obtaining maximum assistance for the child from community resources.

Let us see what might happen to a 10-year-old we'll call Billy. His teacher reports to the principal that she cannot control him in class, that he disrupts the entire fifth grade. The mother, harassed and overtired from coping with four active children, ranging from Billy down to a 6-month-old girl, says that she cannot do anything with Billy at home, to say nothing of making him behave at school. Billy, she admits, is a terrible worry to her, refuses to eat properly, and still wets his bed.

As a result of the public health nurse's consultations with the teacher, Billy's parents, and the family physician it is decided that Billy's problems are too serious to be ignored and that the community has no adequate services to handle them. Through the county health department, arrangements are made for Billy and his mother to go to the visiting child guidance clinic which makes this town part of its circuit.

Billy's mother feels that she can understand him better after these clinic visits. She begins to give her whole family more emotional security, because the tension that has been affecting all of them begins to let up. The public health nurse, who has been consulting with the clinic throughout, keeps in touch with her and also talks with Billy's teacher, and the family doctor. Billy is getting help from all the people who are most important in his life. A community team is in action.

Happy impressions and associations in early years lay foundations for sound mental health.

Relatively simple as this procedure may be, it obviously cannot be established overnight. Billy's teacher saw and recognized a problem. Furthermore, because the community had included mental health in its public program, she had somewhere to take this problem. Such a service does not necessarily need to be located in the health agency. In other communities, the mental-health service for children might be centered in the schools or in an interagency unit. At any rate, this county had a specific person responsible for mental health services, someone who could consult with the

people who knew Billy, decide whether Billy needed outside help, refer him to a suitable clinic, and follow through while Billy's problems were being ironed out.

Help for Billy also depended on people with some training and understanding of mental health concepts. Although the teacher could not help Billy unaided, she knew that he wasn't a "bad boy" and that he needed help. The public health nurse had needed considerably more training and experience to carry out her part. Some of this came from her regular training in public health nursing. More may have come from participation in mental health institutes and workshops. Perhaps she had taken courses at the State university or had actually trained at a child guidance clinic. Also, the mental health program had to have adequate support. Even if the nurse maintained this mental health service only as part of her job, this portion of her time had to be financed by public, community chest, or other funds. The community provided office space in which the clinic could hold its interviews and conferences.

Finally and basically, success depended on cooperation of all citizens, both professional and nonprofessional. If the teacher or any other professional person had been reluctant to get psychiatric aid for Billy, a noncooperative attitude might negate the work of many others. If Billy's mother had not been willing to take her boy to the clinic, little could have been done. Evidently the mental health program of the health department had the confidence of the community because there was adequate understanding of its purposes and techniques.

The clinical psychologist, through a series of tests, learns much about the child's personality.

Only a few of the children with problems require clinic help. However, most children have problems one time or another. How can a community help all its children over the mental and emotional humps of growing up? Can it reduce the need for clinic services by dealing with these problems promptly and constructively?

Staff conferences, in schools, in health and welfare departments, are one way to give people who work with children an opportunity to talk about situations as they arise, to get other people's views, and to work out answers to some of those difficult problems.

The case conference idea as a technique for in-service teacher training has been developed in several places. The University of Michigan and the Mott Foundation have developed a program for training teachers drawn from various public schools in the city of Flint. Introductory sessions give material on child development with emphasis on how the impact of public school experience differs for different children. Teachers also learn specific techniques in counseling, interviewing, and gathering family data, as well as becoming acquainted with community resources. The courses are conducted by psychiatrists, psychologists, and psychiatric social workers, one of the latter serving as course coordinator. Cases discussed are deliberately selected to include some children who do not present problems, this study of notably well-adjusted children serving to highlight facts about mental health which otherwise might not be brought out.

Early study of children helps

In Des Moines, Iowa, a similar project works on a school-by-school basis, bringing teachers to study and work out cooperatively the problems of children they all know.

A community in South Carolina recognizes that teachers need not only training but also time to study the children. During the first month of school, half of the first-grade teacher's time is spent in studying the new pupils, visiting their homes, and carefully recording what she learns about their development and background. This is the start of a cumulative record which is maintained and kept up-to-date as the child goes through school. Each year, part of the teacher's time is allotted to this continuing study, which proves its usefulness in dealing with practical problems that arise in the course of the child's development.

These and other ideas can be applied in other communities, large and small. Basically, their pur-

pose is to help teachers understand the children in their classrooms and become more aware of their problems and of how the educational-social experience of school life affects them. Through this increased understanding, the teachers not only can give more help to the children but also find more satisfaction in their work. Modifications of these projects, of course, are applicable to health and welfare agencies, as well as juvenile courts and law enforcement agencies, scout groups, and other youth organizations. Obviously, no blueprint can be drawn up to give step-by-step procedures in establishing such projects. Like all problems in community organization and action, the mental health program must be tailored to fit local needs and resources.

Clearly one of the first needs is to find people in the community who are interested in helping children with problems. If these people have training and experience in mental health work, so much the better. However, many types of background and experience lead to a concern and responsibility for the welfare of children.

Community workshop a useful tool

For an introduction to the methods and concepts of mental health work, institutes and workshops have proved extremely useful. In Pennsylvania, for example, the idea of mental health workshops has spread rapidly. Usually they are sponsored by local people—schools, parents, and civic groups—and made possible by the State bureau of mental health. A wide cross-section of Pennsylvania citizens and communities are obtaining a broadened vision of what a mental health program can do. Results may already be seen in terms of real action programs in large and small towns. Such workshops last for 1 or 2 days, consisting of talks by psychiatrists, psychologists, and other professionals, plus group discussions in which these experts help the local people work over mental health problems as they affect the community. Mental health institutes usually last from two to three weeks, giving the opportunity for more intensive study — actually a sort of introductory course in mental health.

Teamwork in a California community

A mental health study group has had deep and far-reaching effects on one community in Alameda, Calif. Since 1948 a group of agency workers have been meeting monthly, using the case-conference approach to point up community problems and develop interagency worker relationships. Participants include people from schools, health department, vocational rehabilitation office, juvenile court, welfare agencies, Veterans Administration, and county medical society social service department. Interagency teamwork has developed tremendously, as has development of such services as those for children with cerebral palsy and for retarded children, services given at a speech clinic, and in-service teacher training. Emphasis is on early recognition and referral of children with problems.

As a community program develops, it will require more trained people. Enthusiasm and initiative are needed — but so are experience and knowledge. For workshops and institutes, a community may bring in visiting consultants. For day-to-day program operation, a community must develop its own supply of trained personnel. Social workers will be needed who can serve as liaison between the community and the out-of-town psychiatrict consultants and clinics. They will be needed to coordinate in-service training and discussion groups. A demand may arise for teachers who can teach remedial classes, work with physically handicapped children, and provide other special services. To get these trained people, community agencies may encourage their staff members to take special courses, while an active and growing program will attract the graduates of university and other mental health training courses.

At some point, the community will have to decide whether it intends to build up complete mental health services or whether it will never be able to justify support of full clinic services. A community that decides to aim for a clinic should make an effort to obtain many services on a referral basis until they can be provided by specialists in the community. A smaller community, which frankly will never be able to maintain a clinic, must make more strenuous efforts to train its present personnel and to recruit with an eye to interests and skills for mental health work, or must work out some method whereby children can be transported to a center where services are available.

Most communities will need outside assistance for the most effective development of a mental health program. The National Mental Health Act was passed in 1946, providing grants-in-aid for State mental health work, and today all States have active programs. Many of the State mental health agencies are prepared to give aid to communities in program planning, through assignment of professional personnel for workshops and other training activities, and through financial assistance for projects.

Help comes from many sources

Another place to find assistance is in the universities, particularly those with strong psychiatric training programs. The medical schools, the schools of social work, education, and public health, and the graduate psychology departments all can help. The University of Colorado shows how such a center can help small mental health programs grow. Its traveling psychiatric clinic tours a large circuit of towns around Denver. Psychiatric social workers, trained at the university with the clinic staff, are located in each of these stop-off points to work up the cases and serve as liaison between clinic and community. As the local programs grow, with the aid of consultants from the

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PENNSYLVANIA SPEAKS OUT FOR CHILDREN

Twelve communities focus attention on child-welfare needs

MANUEL KAUFMAN

SOMETHING NEW and exciting is happening in Pennsylvania. Long-distance wires are humming; each mail brings new inquiries; and before long people may even be talking over the back fence about what it means in their community.

What is it?

Briefly this—the Governor's Committee on Children and Youth will conduct open hearings on the unmet needs of dependent and neglected children.

To focus attention on child-care services

Scheduled during May in 12 strategically located Pennsylvania communities, the hearings will provide an opportunity for interested citizens, as well as civic organizations, to make themselves heard about local conditions.

Why have we selected the unmet needs of dependent and neglected children for special consideration this year? Because reports from county committees to the State committee before the White House Conference indicated that many Pennsylvanians are deeply concerned about lack of services for these children.

We are hopeful that the outcome will provide a measure of public opinion which cannot be ignored. Although leaders in the field of child welfare have long recognized the need, the time has come to stimulate public action. If we are to solve this problem, citizen interest is a "must."

The open hearings will, we hope, focus attention on our child-care services and provoke an expression of public feeling about them that will be a guide to public action, including legislative change, in any area of child welfare. It is possible that we also may discover what changes would be supported and whence that support might come.

What does the public want?

If a large and representative attendance is stimulated in many communities and if there seems to be sufficient concern about specific needs, with some indication of how the public would like to see them met, the Governor's committee can arrange for legislation to be drafted.

It is not the purpose of the committee to promote any specific pro-

(Continued on page 142)

MANUEL KAUFMAN is chairman of the subcommittee of the Governor of Pennsylvania's Committee on Children and Youth, which proposed the holding of open hearings on the unmet needs of dependent and neglected children. Formerly Child Welfare Consultant to the Health and Welfare Council of Philadelphia and vicinity, Mr. Kaufman was recently appointed Deputy Commissioner of Welfare for the City of Philadelphia.

ARE CHILDREN OF MIGRANTS THIRD-CLASS CITIZENS?

IN THE MIDST of our generally progressive economy, there exist today thousands of children to whom poverty, privation, hard work, ignorance, and disease make up the normal pattern of everyday life and who cannot look forward with any certainty to a better lot in adulthood unless they receive help soon. These are the children of migrant farm workers in some sections of our country.

The evils associated with the use of migratory labor and their effect on the children of migrants are discussed in vivid detail in a study published recently by the National Child Labor Committee. The report, Migrant Farm Labor in Colorado, a study of migratory families, includes a number of specific recommendations designed to improve migrant living in Colorado. The committee has also published a dramatically illustrated pamphlet, Colorado Tale, presenting in abbreviated form the major findings of the study.

The report was based on a study of 262 families, with 1,513 members. These families comprised a random sample estimated to be about one-tenth of all the migrant families in the State.

Problems of migratory labor have for many years concerned the National Child Labor Committee, Federal and State agencies, and other groups interested in social welfare. The committee conducted this study in Colorado between July and October 1950 at the request of the then Governor, who had created a Survey Committee on Migrant Labor to study conditions in the State and make recommendations to the legislature.

Facts reported in the study will probably be shocking to the majority of Americans who smoke their cigarettes, wear cotton clothing, and stir sugar in their coffee, completely unaware that some migratory laborer, perhaps a child living and working under miserable conditions, has probably harvested the crop that made each of these products possible.

Few of the places where migrant families stop have day nurseries or foster-family homes where children are cared for during the daytime. Many a child like this one spends the day in the field where the mother is working. This picture was taken near Brush, Colorado.

What are families of migrant farm workers like? The survey found that these families were large, averaging almost six members; and it found that children of 14 and younger made up close to half of all persons in the families studied. Although the families interviewed came from 11 States, nearly half were from Texas, and practically all were Spanish American. Approximately half the group spoke only Spanish. The great majority of the parents had had very little schooling, and nearly a third were illiterate.

Why they follow the crops

Economic distress and inadequate job opportunities at home were the most usual reasons for migration by these families. Although only primary reasons for migration were sought and tabulated, many household heads mentioned "wetbacks" (illegal entrants from Mexico) as a contributing cause of their migration. Many of the Colorado migrants said that labor contractors help get wetbacks into Texas; the wetbacks force down wages at home so that "we have to move up here."

The families' annual cash income from seasonal farm work and all other sources averaged $1,424 for the year 1949. Perquisites such as housing, fuel, and water received by some workers would increase this figure somewhat, though the "value" could not be rated very high, considering the condition of much of the housing. Since the families averaged 5.7 persons, average yearly income among Colorado migrant families was about $250 per person.

Housing conditions for migratory workers were generally very bad; the average living quarters were badly overcrowded, dirty, insanitary. Over 90 percent of the families had no means of refrigeration; only one-third could be sure their water supply was safe. Most families used

pit toilets, of which less than one-fourth would have passed elementary health inspection. Sixty percent of the families had no bathing facilities.

A detailed study was made of the diet of these migrant families; and it was found that cheap, starchy foods were their usual fare. Meat was rarely seen; milk, fruit, and vegetables were scarce. Butter and margarine were almost entirely missing. Generally, the amount of food was insufficient.

Migrants had very little health care; the infant mortality rate in migrant families was nearly twice as high as that for the State of Colorado as a whole.

Centers where children were cared for while their mothers worked were almost nonexistent, although more than 100 mothers with children under 10 worked full-time or part-time. In two farm-labor camps the Home Missions Council operated a program of supervised activities for children. But most often children under 10 were taken to the fields and left in sheltered areas —as the report says, "... 'sheltered' in some cases being the shaded side of an onion sack." Others were cared for by older children, elderly people, neighbors, or relatives. Some were left at home unattended.

Little progress in schooling

The findings of the study in regard to child labor and education make up a disturbing aspect of the whole migratory-labor picture. Data on child labor and school attendance were not easy to get; in two areas, according to the study, "Regardless of size, birth date, or other factors, children at work who were asked their ages tended consistently to be '16 years old my last birthday.' "

Most of the children 7 to 16 years of age worked on crops. The work periods of the majority of children were spread over 7 months; leaving only 5 for school. The average working day was between 8 and 9 hours; but, according to the study, almost one-third of the children who worked, worked from 10 to 12 hours a day.

As would be expected under the circumstances, retardation in schooling was widespread. When data for 372 children 7 through 16 years of age were analyzed by age and last grade completed, it was found that none of them, regardless of age, had gone beyond the fifth grade. The great majority of children 10 through 16 had not gone farther than the first or second grade. Only 49 children of the total 372 had completed the grades normal for their age.

Lack opportunities to learn

"This does not mean," the study points out, "that these migrant children are less able to learn than other American children because of ethnic or geographic origin which makes them 'different,' as the prejudiced frequently claim. It simply means that no children can make normal educational progress unless they can attend school regularly and are given the opportunity, if they are second-generation Americans, to learn the language, the customs, and the culture of the country of which they are citizens."

When parents were asked why their children were not in school the usual replies were: They "had to stay home to care for younger children"; their "earnings were needed"; they "didn't speak English"; or they would "start school back home."

Children come home from school crying

After the confidence of some of these parents had been gained, however, other reasons for nonattendance were uncovered. The following statement, according to the report, was typical: "Our children were sent to school. If the schools were not too crowded or if the children were not sent home for other reasons, they would come home crying and begging us not to send them back. Why? Because the other children made them feel that they are different. Their clothes are not so clean. Sometimes the shoes are too big or worn out, and the other children laugh at them. . . . Everybody laughs at them because they speak so funny. Then because they cannot understand easily, they are thought to be stupid. . . . Our children do not play the Anglo games well. They stand by the sides and are called names and made to feel ashamed. . . . Juan is the biggest boy in his class. Even the teacher thinks he is dumb. But, believe me, he has never had a chance to go

Space between tents is the "playground" of these youngsters, who are the children of migratory agricultural laborers. This picture was taken at a camp near Fort Collins, Colo.

to school. So you see, we keep our children home—not to make them work, but because it is not so bad as seeing them come home crying."

Truant officers who were questioned described the difficulties of enforcing school attendance among migrant children and pointed out that enforcement would be in opposition to the wishes of the community, their own friends, and the workers themselves. The truant officers felt that it would be better if a program were set up to educate the parents and the community in the value of school attendance before enforcement is begun.

School superintendents were aware of the need for stronger compulsory-attendance laws and more attendance officers, but beyond this they also saw the problem of providing enough space and enough teachers for a seasonal overload and the problem of how to make short periods of attendance profitable for children who are retarded and constantly on the move.

Specific measures recommended

The study made by the National Child Labor Committee is broad in its scope and goes beyond problems related directly to the children of migrants. Employment and income problems; questions of recruitment, placement, and transportation; discussion of social participation and community attitudes are included in the report.

Recommendations that the committee drew up are designed as specific measures to unravel some of the problems of migratory labor in Colorado. The committee's first recommendation is that a State commission on migrant labor should be established, composed of representatives of all State agencies concerned with seasonal agricultural labor and of representatives of the general public. The commission would coordinate and give direction to the programs of agencies dealing with the problem. It would direct research, make recommendations for legislation, and assist local groups to develop programs that would interpret the workers to the community and the community to the workers. It would promote regional agreements with other States.

A series of detailed recommendations are made regarding the health of the migrant families, their housing, the education of the children, child labor, recruitment, wages and income, and public-assistance programs.

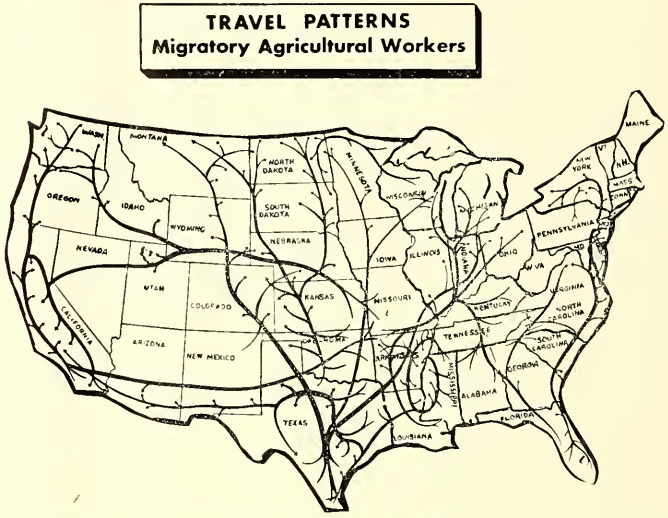
The need for a State-wide health program for agricultural migrants in Colorado is as real as the need for their occupational services in the State, the report says, offering recommendations that the committee considers essential not only for the welfare of the migrant workers and their families, but for the safety of the community at large.

Noting that seasonal agricultural workers are a highly mobile group and that communicable disease easily spreads from one community to another, the committee urges a number of health measures aimed at preventing epidemics. Special detection and treatment clinics and health services should be made available to migrant workers and their families, the report says. Bilingual, and preferably well-qualified, Spanish-American personnel should be employed for these services, the committee recommends. Clinic services should be available after working hours.

Mobile clinics and camp clinics are needed, according to the recommendations, and these should include, among others, clinics for children, and clinics for prenatal and postnatal care. Among the other services recommended are public-health nursing, mental-hygiene consultation services, and popular health-education activities.

The possibility of additional assistance through the Federal grants-in-aid programs administered by the Public Health Service and the Children's Bureau, both of the Federal Security Agency, should be investigated, the report says, with a view to increasing State personnel and facilities available for health, sanitation, and inspection programs for migrant workers.

For the improvement of education among migrants, the committee recommends several specific methods for increasing efforts to obtain school attendance, increasing financial assistance to schools in areas with migrant children, improving educational facilities for such children, gaining acceptance of them in the schools, and extension of adult education.



Colorado is only one of the many States with problems concerning migratory agricultural laborers and their families. As the map shows, these workers travel through many States.

Several revisions in the Colorado child-labor law are recommended by the National Child Labor Committee. The present provision establishing a minimum age of 14 for most occupations should be amended, the committee feels, to include, specifically, commercial agriculture. The committee recommends also that the law be amended so that it will be illegal to employ children under 16 in any occupation, including farm work, during the hours the schools are in session. Work permits, based on proof of age and a certificate of physical fitness, should be required for the employment of children of 14 and 15 years in commercial agriculture outside of school hours, according to the committee's recommendations.

Explaining its recommendations the committee says:

"The use of migratory farm labor in Colorado, as elsewhere, creates difficult problems for the migrant workers, for the family members who accompany them, for the growers who rely on their labor, and for the communities where they temporarily reside.

"Poorly housed, poorly paid, poorly educated, poorly protected in legal ways, the migrant lives and toils under shockingly substandard conditions. For him and the members of his family, the problems of migrant living are problems of human misery.

"The grower—the employer of migrant labor—has his problems too, different in nature but equally real," continues the report. "He has a highly perishable crop, which, under the dictates of nature, must be handled and harvested during a certain, short period of time, or be lost. He cannot obtain suffiicient labor for his needs from within the local community and must rely on the uncertain stream of laborers from outside the area.

"As an employer, the grower would prefer, if he could, to limit his responsibilities to these temporary workers to the payment of a fair day's wage for a fair day's work, and not concern himself with such matters as housing, health, the care and schooling of children, which are problems not ordinarily faced by an employer in his relation with his workers.

"But," says the report, "if he is at all concerned with building a more stable labor force upon whom he can rely season after season, if he is concerned about productive efficiency, he cannot afford to ignore these problems of his workers, because a dissatisfied worker is a poor and unreliable worker and one whose anxieties and discontent inevitably lower his dependability and productivity.

Communities are under moral obligation

"The communities to which migrants come have their own difficulties also—difficulties multiplied by the needs of tens of thousand of temporary residents for housing, health, welfare, and educational services which already may be inadequate even for the resident population.

"Nevertheless," the report says, "each community where migrants live and work has an obligation—moral if not legal—to meet the basic needs of their temporary residents, and it is indefensible to set them apart as second-class citizens for whom community services should not be made available.

"The migrants are productive workers, vitally necessary to the economy of the community, and by their labor they contribute to its wealth and prosperity. Each community which they enrich has the corresponding obligation not to deny these temporary residents the services and facilities and protective legislation available to others," says the committee.

"In considering these problems, the report goes on, "the fact must be faced that the need for migrant labor in Colorado will remain for a long time, although it may be reduced somewhat by basic changes in methods of agricultural production, such as fuller development of mechanization, or by slow changes in the agricultural economy or in the population patterns of the State."

The recommendations of the committee do not outline a Federal program. "It is assumed," the report says, "that the National Government will increasingly recognize its responsibility in dealing with this problem, which has many inter-State aspects, and it is also assumed that migrant workers should be given the protection offered to other workers under our social-security system and our Federal labor legislation. But the chief hope for immediate improvement of existing conditions," says the report, "lies in a planned and coordinated effort by State and local agencies, cooperating with Federal agencies as a national program is developed. These recommendations suggest action that can be carried out through existing agencies of the State of Colorado, through regional agreements with other States from which migrant workers are recruited, and through action in the communities where migrant workers are used."

"None of these recommendations is theoretical or impossible, the committee maintains. Many have been tested and proven practicable in other areas of the Nation with migrant problems similar to Colorado's.

What of the cost?

"Recommendations are one thing; their realization is quite another," the report goes on to say. "Putting these recommendations into practice will require more than will and wisdom. It will require also an expenditure of funds. The National Child Labor Committee has no wish to shy away from that difficulty by refusing to mention it," says the report. "But the costs are neither extravagant nor great, by any measure. They do not contemplate luxury levels of living—only the barest level necessary for minimum standards of health and decency. The costs involved in the recommended programs," says the committee, "are in reality only a modest capital investment in people who are necessary to Colorado's prosperity, and will assuredly yield satisfying dividends in human happiness and increased productivity."

MENTAL HEALTH

(Continued from page 136)

university, they are able to recruit staff from among the graduates of the university schools.

The National Association for Mental Health and its affiliated mental hygiene societies can help with materials for both professional and lay education, as well as community organization. It is concerned with public information and fund raising. In most counties there are local groups and individuals with valuable experience in community education and service — the health council, the tuberculosis association, the cancer society, the women's club and civic groups, the county agents and home demonstration agents. Parent-teacher groups, of course, would have a prime interest in a mental health program for children and would be among the first to participate.

It is still extremely difficult for the smaller community to obtain help for its children with problems. The dearth of professional personnel plus the geographical distribution of psychiatric services present serious obstacles. Nevertheless, as this article suggests, new ways are being developed to bring psychiatric services in reach of outlying areas and, by bridging the gap from the other end, to help the people of these communities organize and educate themselves to do a large part of the job. Generally speaking, the small community program seems to be highly effective when, like the Alameda program, its basis is interagency and, like the programs in the Colorado towns, it maintains close affiliation with a university center. Developed with care and under competent professional guidance, such programs can conform to sound professional standards. Built up, as they must be, through intense local interest and efforts, they will have strong support and be based firmly upon real community needs.

Reprints in about 6 weeks from the National Institute of Mental Health, Bethesda 14, Md.

PENNSYLVANIA

(Continued from page 137)

posals through these hearings. In a sense, they will be public-opinion polls. It is our purpose to find out whether the people of our State believe that local child-care resources are adequate in quality and quantity, what needs they recognize, how disturbed they are about those needs, and what suggestions they have about how the needs might be met.

Everybody welcome

We hope to gain the attendance of representatives of labor, business, veterans' organizations, civic groups, schools, and welfare agencies. Our aim is to draw to these hearings the general public, together with the lay and professional people in the field who have been trying for more than 20 years to get essential changes in Pennsylvania's machinery for child care.

Testimony will be heard on the adequacy of services provided to the following groups:

Children who must be cared for in foster homes or institutions, most of whom are maintained at public expense.

Children living in their own homes who are neglected, mistreated or exploited by their parents or guardians, or who are in danger of becoming delinquent.

Unmarried mothers who need help in obtaining proper care for themselves and in making plans for their babies.

Children whose parents wish to place them for adoption.

Children with mental and physical handicaps whose parents need help in arranging for special facilities.

Children with problems of personality or behavior that seriously interfere with their getting along in school, at home, or in the community.

What care are the children getting?

We want to obtain a composite picture of child-welfare needs. We are not attempting to gather statistics, but rather to make clear what experience has revealed at the grass roots of Pennsylvania about the quantity and quality of child-care services.

Many fields represented

The hearings will be confined to one subject—the unmet needs of dependent and neglected children and suggestions for meeting these needs. Statements will be limited to 10 minutes each, so that we may learn the opinions of many people. We request that the statements be written and that two copies be presented to the hearing panel. It is intended that the hearings will have a formal air because of the seriousness of the problem. Members of the Governor's committee will serve on the hearing panels; and it is significant that committee members who were chosen because of their interest in other fields, such as health, recreation, and education, have welcomed an opportunity to participate in the hearings.

Citizens can speak out

The Governor's committee has no magic flute with which to draw people to these hearings and to insure that they will make statements based on facts. The committee can and will invite every organization interested in child care to make a statement. We are arranging with the officers of State organizations to urge local members to attend and make statements.

Whether attendance is good and whether the statements are based on accurate information will depend on how much interest we are able to create. The Governor's committee will issue invitations, provide the setting, and take the testimony. How many speak, and how pertinent is their testimony, is up to the public.

In Pennsylvania these open hearings will provide a unique opportunity for every citizen who cares to speak out for children.

• IN THE NEWS

An advisory committee on delinquent and socially maladjusted children and young people, serving the International Union for Child Welfare, will meet at Rome, Italy, some time between September 28 and October 4, 1952. The committee desires to invite qualified United States workers to attend this meeting, the subject of which will be "The Choice of Treatment." Juvenile-court judges, psychologists, educators, psychiatrists, social workers, heads of training institutions for delinquents—these and others will be welcome. Write to Mrs. J. M. Small, Deputy Secretary General, 16, Rue Du Mount Blanc, Geneva, Switzerland.

Summer Courses

Louisiana State University. School of Social Welfare. Baton Rouge 3.

Some of the short courses. Workshop: Children and public-welfare agencies (June 30 to July 18). Institute: Public relations of public-welfare agencies (July 18 to 19).

Some of the 9-week courses (June 6 to August 9). Social services for children; children in foster care; and visiting-teacher work.

Nursery Training School of Boston, Boston 15, Mass. For experienced nursery-school or kindergarten teachers: A special course in teaching young children who are crippled, blind, or deafened. Regular courses in early childhood education for students who have done some work in this field. Also a try-out course for high-school students and others who are considering entering the field of early childhood education (June 30 to August 8).

University of Michigan. School of Social Work. Ann Arbor.

Besides the regular courses, and a new program of 2-week institutes, a workshop in human behavior will be provided under the auspices of the School of Education, the Department of Sociology, the Department of Psychology, and the School of Social Work. The workshop is an integral part of the University of Michigan Fresh Air Camp, near Pinckney, Mich., a group-therapy project for 240 maladjusted boys sent by some 30 cooperating social agencies. Students spend half their time in supervised counseling activities and half in related courses (June 23 to August 16).

Washington University. The George Warren Brown School of Social Work. St. Louis 5, Mo.

Social case work; Social planning in an urban area; Disease and its social component; Methods of social research. First term (June 16 to July 25).

Psychiatric aspects of human behavior. Second term (July 28 to August 29).

• FOR YOUR BOOKSHELF

MOTION PICTURES ON CHILD LIFE; a list of 16-mm. films. Compiled by Inez D. Lohr. Federal Security Agency, Social Security Administration, Children's Bureau. Washington, 1952. Processed. 61 pp. 40 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C.

This list of films relating to all aspects of childhood was prepared by the Children's Bureau to answer hundreds of requests for such information from the general public and professional people who work with children. It is the first such list that the Bureau has prepared.

The list includes more than 450 films on social, medical, mental, and developmental aspects of child life.

Each film is briefly described, but no attempt has been made to evaluate the individual films.

THE ADOPTED FAMILY: Book I, YOU AND YOUR CHILD: a guide for adoptive parents. 64pp. Book II, THE FAMILY THAT GREW. [A story book for the adopted child.] 20 pp. By Florence Rondell and Ruth Michaels. Crown Publishers, Inc., 419 Fourth Avenue, New York 16, N. Y. 1951. Two volumes, boxed, $2.50.

So far as I know, this is the first time an effort has been made in book form to give advice to adoptive parents about situations that they must face.

The authors omit some things that trouble adoptive parents, but what they do tell is extremely helpful and reassuring. They discuss establishment of the new family, and emphasize that the adoptive parents are the child's **real parents.**

Suggested ways of announcing the arrival of the child, what not to tell interested relatives and neighbors, explaining adoption to the child, answering his questions about his biological parents, and the adolescence of the adopted child are some of the subjects considered in the book. It also contains a list of recommended reading for parents.

When the authors discuss telling the child about his adoption they suggest that the parents read aloud to him "The Family That Grew," from the time he is 5 years old, to help him understand how he and his parents came to be a family. They suggest that the small child will enjoy looking at the pictures, and that later he can read the book himself. From personal experience, however, I believe that the child can and often should be given the word "adoption" to add to his vocabulary before he reaches the age of 5. A little child is as likely to enjoy a story about adoption as any other story.

"The Family That Grew" begins with the birth of the child. It explains to him that the parents who started him could not keep him and therefore went to a "special person whose job it is to know about children," asking her to find the right father and mother for him to grow up with. It says, "Choosing a child is called adopting a child," and stresses how glad Daddy and Mommy are that they adopted this particular child.

I. Evelyn Smith

Illustrations:

Our cover picture, published through the courtesy of the United Nations International Children's Emergency Fund, shows 5-year-old Anjum Chhatari, daughter of the First Secretary of the Pakistan Delegation to the United Nations. Anjum is holding some dolls that were presented by Pakistanian children to the UN representative in Pakistan in gratitude for help given by UNICEF in building up and extending its child-health and child-welfare services and in attacking malaria, tuberculosis, and other diseases that attack large numbers of children.

Pages 133 and 135, U. S. Public Health Service, Federal Security Agency.

Page 134, U. S. Army photograph.

Page 137, Edward Steichen.

Pages 138 and 139, courtesy of the National Child Labor Committee.

Page 140, Extension Service, U. S. Department of Agriculture.

THE CHILD

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MAY 1952

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C.

For others the subscription price is $1.25 a year. On all orders of 100 or more sent to one address there is a discount of 25 percent. Send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies 15 cents each.

Foreign postage—25 cents additional—must be paid on all subscriptions to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

• CALENDAR

June 1-5. National Conference of Jewish Communal Service. Fifty-third annual meeting. Chicago, Ill.

June 2-4. President's Conference on Industrial Safety. Washington, D. C.

June 7-8. American Diabetes Association. Twelfth annual meeting. Chicago, Ill.

June 8 (opening date). International Labor Conference. Thirty-fifth session. Geneva, Switzerland.

June 9-13. American Medical Association. One hundred and first annual session. Chicago, Ill.

June 14. Canadian Welfare Council. Thirty-second annual meeting. Quebec, Canada.

June 16-20. Biennial Nursing Convention. American Nurses' Association, National League of Nursing Education, and National Organization for Public Health Nursing. Seventeenth meeting. Atlantic City, N. J.

June 22-25. National Congress of Colored Parents and Teachers. Twenty-sixth annual convention. Institute, W. Va.

June 23-25. American National Red Cross. Annual convention. Cleveland, Ohio.

June 23-28. American Physical Therapy Association. Twenty-ninth annual meeting. Philadelphia, Pa.

June 24-27. American Home Economics Association. Forty-third annual meeting. Atlantic City, N. J.

June 28. American Hearing Society. Thirty-third annual meeting. Chicago, Ill.

June 29-July 4. National Education Association. Ninetieth annual meeting. Detroit, Mich.

To Our Readers—

We welcome comments and suggestions about **The Child.**

☆ U. S GOVERNMENT PRINTING OFFICE: 1952-952609

THE CHILD

JUNE-JULY
1952

WHAT ABOUT THE AGGRESSIVE CHILD?

GEORGE E. GARDNER, Ph.D., M.D.

BY WAY OF definition let us merely say that the aggressive child is the youngster who does a lot of attacking. This "attacking" is usually mild physical attacking, with hands, feet, fingers, and thumbs, and all the extensions that he can add to them in the form of bothersome or painful gadgets.

A child's aggression may, however, take the form of moods, such as moroseness, uncommunicativeness, pouting, anger. Or it may exhibit itself in words — choice and fancy words, sharp, cutting, or impolite words.

Whatever one of these media of expression he uses, he is attacking someone; and if this type of behavior becomes a pattern, repeated over and over again, we say he is an "aggressive child."

I am not urging anyone to ignore the aggressive child as a harmless youngster who will, if you ignore him, necessarily outgrow his annoying behavior. For he may not outgrow it, and then he will get into real difficulties. But rather, I would say, let us examine the aggressive type of behavior to see if we can better understand what the child is trying to do through his aggression (in fact what he has to do if he is to develop normally).

I would like to emphasize the value of aggression as an ingredient of any child's personality and to consider certain aspects of normal aggression that particularly plague us, and, in turn, to consider the aspects that signal to us that we must get help for the child in order to insure his future adjustment, efficiency, and happiness.

Aggressive behavior normal

I believe that every human being—in fact all living tissue—is basically aggressive toward its environment—whether the environment of things or of people. It is through acts that are aggressive (in the sense of seizing and devouring) that we are able to sustain ourselves at all by means of our food. And once the food is within us, we can utilize it for heat production, body repair, and growth only through "destroying" it by means of chemical changes.

Our sensory and motor systems enable us to accomplish this aggressive "attack" on our food. Thus is evident a biological pattern of behavior that enables us to understand a lot of the behavior of human beings, though the element of aggressiveness may be very well covered up, and seemingly absent. So I maintain that the child is aggressive by natural endowment. He is motivated by an "instinct of aggression."

A baby is born with aggressive impulses—a tendency toward aggression. This tendency, even if it isn't always "good," acts, in the long run, to serve his best interests.

I want to show you, first, that this behavior we call aggressive is inevitable, because we are born with such a tendency; and even if it isn't always "good," it is, in the long run, active in serving our best interests.

For what kind of world would we have if we had no aggressive impulses at all? If we lost the impulse to destroy, to possess, to be aggressively curious about, to explore in the face of frustration and obstacles, to master the physical environment about us, not only would we have uninteresting, uninformed, and uninformative people; we probably would have no people at all—and no life. This is a difficult notion for us to accept just after we have seen the hideous results brought on by a war motivated by the very same impulse. But the thesis seems to be correct.

This consideration of both the good and the bad aspects of the aggressive impulse—whether seen in the light of individual behavior, or of social group behavior, or of the behavior of nations—impels us to try to differentiate between the type of aggression we can reasonably and morally denounce as harmful and the type we can sensibly and even enthusiastically endorse. What kind of differentiation is there? Can it be applied in the care and treatment of children?

The most fruitful differentiation that we can make is that although at first the child's aggressive behavior aims at destruction or elimination of something, the destructive aspects of aggression can be minimized under our influence, and the constructive aspects brought to the fore. Our natural biological reservoir of aggressive energy cannot be drained off, nor can it be dammed up and not expressed at all. But the great bulk of it (we hope all) can be deflected into channels that will demonstrate the child's control of himself, and that will express his mastery (in the good sense of the word) of the world about him.

Accomplishment of this deflection of the aggressive impulse seems to me to be the child's main task in his development, and we must aid him in this task. There may be other developmental tasks that are important, but this one seems to me to overshadow them all. And all parents, I believe, who have observed their children carefully as they pass through various stages in development will agree that the child's ever increasing power to control his aggressive tendencies toward his parents, his brothers and sisters, and his playmates is the most remarkable feature in his behavioral growth. And nothing is more alarming than to find that this expected control of aggression is not taking place and that the child at times seems overwhelmed by his infantile aggressive impulses.

Two important changes

First, let us consider the nature of the change that must take place in the way the child expresses aggression as he develops and, secondly, let us examine the best setting in which such a necessary change can take place. This setting, of course, is primarily the family. We do not know how these changes take place—at least in minute cause-and-effect detail. We only know enough to cite the conditions that must exist in order to bring out these changes.

1. In the first place, as the child gets older he must modify the aim of his aggression. At first, and for a number of years in early childhood his aggression is aimed primarily at destroying, eliminating, breaking up, mutilating, the body or possessions of another person. But gradually he replaces this aim by socially acceptable aims, which merely symbolize such destruction. The fantasied soldiers, cowboys, gangsters, Indians, and supermen of the extremely aggressive stage between 5 or 6 years and 10 or 11 years are examples of this partial modification of the child's destructive aims through fantasy and indicate a stage in his learning to control aggression. We must recognize this phase for what it is and not hastily conclude that it is either wrong or abnormal. Only if this stage is prolonged into adolescence should it worry us.

Coupled with this change in the direction of more fantasy and less harmful intention, the child increases his aim to "master" (not harm or kill) the other person in the environment—to try to make him or her do his bidding. He tries harder to overcome the frustrations and blocks and limitations placed in his way by persons and even by nature; that is, by gravity, physical ability, size, and so forth. In short, a desire for mastery of the world and its occupants replaces the aim to destroy or damage them; and herein we discover the elements of constructive and worthwhile aggression.

2. An equally important change in the character of aggressive behavior in children, which should take place in the early years, is the gradual "impersonalization" of the object against which the child is hostile or aggressive. In the earlier years the child directs his aggression against the people about him—his parents, or his brothers, sisters, playmates. But just as the aim of aggression changes from destruction to mastery, so also does the object of these aims change from persons to things. A frustrating thing, event, or set of circumstances gradually replaces a person as the object of aggression, and though the acts of aggression are in earliest years minor and imperfectly carried out, later they can lead to the most constructive alterations or contributions — individual and social — that we can make.

When the aim of the child's aggression shifts away from persons it must be redirected, not only away from parents and brothers and sisters, but also away from playmates and schoolmates, and groups of people who differ from the child in race, religion, or economic standing.

An adult who forever remains a child in this aspect of his development will always need a person or a group of persons against which to hurl his hostility. Such aggression (in this form or guise we call it prejudice) is really a continuation of the child's battle against others than the hated group, and is in reality a sham battle against a feared or suspected enemy of very earliest years.

Now it is important for us to examine how this orderly and much-wished-for development takes place at all, in order that we may prevent unfortunate deviations, blocks, or delays in the development of our children as they endeavor to control and use their aggressive impulses.

As I said before, we don't know the detailed "how" of the process, but we have a fairly definite idea of the only setting in which the child will be able to develop along these lines. We recognize, in the light of repeated case histories and of intensive studies of children at all levels of development, that primitive aggressive responses can be modified in the manner outlined here only when the child senses he is not in danger.

Feeling of security needed

If the infant (or even the school child or the adolescent) senses a feeling of hostility, rejection, lack of love or interest on the part of the most important people in his environment (his parents), the destructive aspects of aggression and those directed against people are called forth, and the expected modification (toward impersonalization and constructive mastery) will not take place.

Actual or implied threats of abandonment or desertion by either or both parents, bodily harm, and corporal punishment will not only tend to block the development of the child in this area, but will even tend to undo the advances already made. In the latter case, destructive-aggressive acts directed against actual persons result.

Thus, the unwanted type of aggression is seen to arise when the child's anxiety (or sense of danger) is aroused by impending insecurity.

Paradoxically enough (and it is a paradox puzzling to all students of child development and behavior), the

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DR. GEORGE E. GARDNER is Director of the Judge Baker Guidance Center, at Boston. He is also Editor of the *American Journal of Orthopsychiatry*. Dr. Gardner has based this article on an address that he gave as part of the Judge Baker Lecture Series in Boston.

Occasional scraps, fist fights, and shovings around are part of youngsters' normal behavior.

more primitive type of aggression (against persons) cannot be given up—nor can the nonpersonal type be given expression to—except in a family environment that makes the child feel secure. The danger that hostile feelings may replace secure relations with his parents makes for an anxiety that can allow him only a repetition of the older protective aggressive responses and that inhibits all attempts at newer types of response. In short, learning and development cease in such a milieu.

These, then, seem to be the steps that the child is confronted with in his attempts to gain control of his aggressive instinct and obtain a socially satisfactory expression of it. (I have emphasized the home setting necessary for carrying out this task in development.)

Before passing to a discussion of the types of aggression, good and bad, that we encounter in children, I would emphasize, too, control of aggression is a continually reappearing task, which we ourselves have to regain each day in our relations with other people. We have continually to modify our aggressive wishes toward others so that these wishes are not harmful to their person or character, and repeatedly we have to find new outlets of a nonpersonal nature—things, good causes, social ills—for our aggression.

Particularly in relation to our children in their most "pestiferous" moments, do we have to modify in our outward deed and word the aggressive impulses that their behavior toward our persons, our possessions, our property, and our edicts may bring forth.

Why does a child act like that?

Let us consider now what are the various purposes for which an aggressive act is used by children. In the light of some of the meanings and purposes of this behavior, we may be the better able to cope with it when it arises. (Understanding an act, unfortunately, doesn't always call forth immediately an infallible method for dealing with it—but it does help us guide our own behavior in relation to it.)

1. Aggression as attention-getting. With a young child the very appearance of the parent or other adult may be a signal for him to become aggressive toward his brother or sister—or even toward an adult in the group. It is obvious that such behavior is an attempt to gain and hold, exclusively, the attention of the adults present. It is as if the child were threatened by the presence of another child, in that the other might draw unto himself the love and attention that the aggressive child feels he must have. Hence, the aggression is but a thinly disguised attempt to eliminate the other child from competition. Also, unfortunately, many times the child has in some way learned that a show of aggression or "fighting spirit" is not only condoned by the parent, but is in fact encouraged as a sign of accomplishment—an indicator of masculinity, a badge of courage. Thus the child immediately starts his aggressive, attention-getting act when the adult appears.

2. Aggression to demonstrate superiority. Closely allied to this first type of aggression is the type that is designed primarily to demonstrate a child's superiority over others in the group. This type of hostility is seen in younger children, and it is not unusual for a child to try it in the family group. The aggressive child may be unable to obtain the satisfaction of being loved and wanted, through his usual behavior; hence he has to gain this satisfaction by impressing the adults with his physical superiority. Children who are inferior physically, owing to slow development, or handicaps, will tend to be aggressive toward younger, smaller children in order to gain actual or fantasied recognition.

3. Protective or defensive aggression. A child who has been hurt physically or emotionally, or one who fears that he may be about to be hurt in either of these ways, will sometimes become very aggressive as a defensive measure. This is "counteraggression" and is the response to actual or threatened frustration. Here again the aggression used in "defense" can be directed at persons, or it can be of the more mature, nonpersonal type. Many child psychiatrists and child psychologists stress counteraggression, as a response to some frustration, almost to the exclusion of all other types.

4. Inverted aggression. There are times when the child directs his aggression not against the outside world, but against himself. We say his aggression is "inverted." Here the child seems to wish unconsciously

to punish himself for misdeeds for which he feels guilty. Two examples will illustrate this:

(a) In a temper tantrum the child in frenzied fashion is violently aggressive toward himself, with blows and banging of his head and body on the floor. His aggression, usually aroused as a response to some persistent frustration in the environment, is expressed both against the outside world and against himself at the same time.

(b) Another and much more subtle way in which a child (and often an adult) inverts his aggression and directs it against his own body is seen in the "accident-prone" child. Some children so repeatedly get hurt, or get themselves into positions where it is inevitable that they be hurt, that we recognize in such children a strong unconscious drive to punish themselves—to cut and bang and scrape themselves as if there were an unconscious compelling force (such as guilt) making them do it. Analysis usually shows that the child feels a strong need for punishment, and he is fulfilling this need by allowing harm—physical harm—to come to him.

5. Punishment-inviting aggression. A more common variant of this type of aggression toward the self is use of aggressive behavior to invite punishment by the parent. In other words, the child may feel guilty on account of some wrongdoing that has not been found out, and for which he has not been punished as he feels he should be.

Such a child may engage in open and perhaps very serious aggressive acts in order that he may be punished by the parent for them—this punishment in turn resolving his feeling of guilt and need for punishment for the aggression, and for the undetected evil-doing as well.

This mechanism is seen at work quite frequently in delinquent boys and girls who engage in delinquent acts again and again, until getting caught and being punished makes them feel better. Many accurately predict their future detection and punishment by the police and courts.

Such boys and girls are seeking punishment by their aggressive acts for some other crime or wrongdoing they dimly think they have committed, and they will continue to do this until they receive help and attain insight concerning their own unsuspected drives. (Such observations in children give us pause as we ponder whether "To punish or not to punish" when we are confronted with childhood misdemeanors in our own children.)

6. Aggression arising from a fantasied accelerated development. Particularly in adolescence, some children are prone to become increasingly aggressive toward their parents—or toward all people who stand in the position of parents, plus those who stand for authority in general. Such aggression may spring from a fantasied maturity—a spurious and unreal assumption of an adult status which often is a temporary phase in adolescent growth. Here the child determines to free himself prematurely from the dependency status of childhood and he uses aggressive acts of an adult nature to prove his maturity.

7. Aggressive devaluation. Allied to this type of adolescent response is the tendency on the part of the youngster to devaluate aggressively all the supposedly good points and attributes of the parent and the parent's world. Such devaluation may exhibit itself in nonconforming acts, but it is just as often expressed in aggression through words. "And all this," the parent thinks, "after I have tried for some 12 or 15 years to help the child modify his aggressions! Now he turns it on me, myself!"

8. Educative aggression. Finally, there is that portion of our great store of aggression that is used in furthering the learning process—in education. We are not quite sure yet wherein, or at what point, or by what means aggression is used in the learning process, but it is of great importance.

We know that to be stimulated to learn—to find out—to be curious about—one must act aggressively toward one's environment. Knowledge must be "dug out" through sustained self-application and aggressive attacks on problems, for it never accrues to the passive, inert child who sits back to be fed some information.

You will remember the paradox I cited before, wherein it seems that destructive aggression cannot be given up, nor can constructive (educative or learning) aggression be expressed except when the child feels secure, wanted, and loved. And we must have this constructive aggression—this ability and freedom to try new habits, words, ideas, subjects, professions—if education and growth

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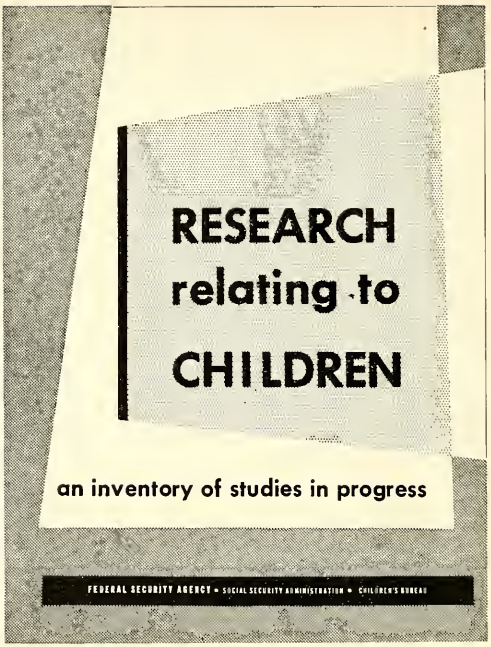
Children who have a secure, loving relationship with their parents are the ones who feel free to express constructive aggression in the sense of learning new habits, words, ideas.

COOPERATION IN RESEARCH ABOUT CHILDREN

Children's Bureau Clearinghouse keeps research workers abreast of current projects



IN PEDIATRIC clinics, juvenile courts, nursery schools, universities — wherever people are concerned with children — research workers are trying to discover knowledge which parents and professional workers can use to promote the well-being of children. Individuals and groups are studying such widely varying subjects as adoption practices, infant feeding, racial prejudice in children, birth histories of children who develop cerebral palsy, sudden deaths of apparently healthy infants. Making these studies are pediatricians, nutritionists, probation officers, educators, social workers, psychologists, and many other representatives of the numerous professions that are concerned with helping children to achieve healthier and happier lives.

Many research projects take months or even years; and then more months or years may intervene before the results are available in professional publications. Some research workers have felt that their own work might be modified and made more effective in the light of the experience and preliminary results of others working on similar problems.

Moreover, during the past decades it has become increasingly clear that all aspects of a child's life—his home and school environment, his physique, his personality and behavior—are interrelated. Therefore, it has become recognized that a worker doing research on any restricted aspect of the child's life needs to be aware of the relationship of his study to other studies.

As a result of these considerations, research workers recognized the need for a center where they could find out what studies others were engaged in, both in their own field and in related fields.

Professional organizations, as well as individual workers, began to request that the Children's Bureau establish a systematic way of keeping research workers informed of current projects as they are planned and as they develop.

Clearinghouse established

About 4 years ago the Bureau called together representatives of various professions concerned with research on children, to review what was going on in research in child life, and to consider ways in which needed research could be stimulated. As a result of the recommendations made at these conferences the Clearinghouse was established in the fall of 1948. Since then the main work of the Clearinghouse has been preparation of inventories of current research related to children.

As the first step in preparing such an inventory, the Clearinghouse canvasses scientific investigators, requesting brief information on any research they are doing that is directly related to children (from the prenatal period to 18 years of age).

The basic information requested relates to the purpose of the study, the research design, and the sampling.

In addition, the investigator is requested to state his plans for publication of the study and indicate whether the research represents work toward an academic degree.

Up to the present, the Clearinghouse has published one bulletin, with five supplements, representing nearly 3,500 projects. These publications are available to individuals and organiza-

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SOCIAL CASE WORK HELPS DISPLACED FAMILIES

ROSE E. DRAPKIN

EVEN THOUGH years have passed since World War II uprooted so many European families, displaced children are still coming to the United States to find new homes.

Some have no parents, and enter as "eligible displaced orphans," as they are called in the Displaced Persons Act of 1948 (amended in 1950). Many more have come with their families, for the act permits a displaced person who is eligible for admission to bring his or her spouse and unmarried children under 21, if they are otherwise eligible for admission.

These children, especially the older ones, have been through devastating experiences. Many, it is true, were born after the worst was over. But all have lived under conditions that are likely to bring on later emotional disturbances. For even the children who are fortunate enough to have their parents may suffer from the family's displacement and from a belief that their parents feel insecure.

When such children arrive in our country, their feelings of insecurity are likely to be intensified rather than lessened. But at this point much can be done for them by a social agency that understands what the experience of displacement, immigration, and resettlement can mean to children, as well as to grown people, and is prepared to help with the necessary adjustments.

One such agency, which offers a complete program to help the foreign-born integrate themselves into American life, is called United Service for New Americans. It was formed in 1946 through consolidation of the National Refugee Service and the National Service to Foreign Born (of the National Council of Jewish Women). One branch of its program consists of specialized services for children.

When social case-work services are needed to help individuals and families adjust to their new surroundings the agency provides such services.

Everything about the immigration of a family naturally affects the children. But the problems of children who are unattached—those who come alone to the United States—are more difficult. Obviously, the process of admitting the child legally to this country cannot provide for the planning that is needed when a child is to be placed in a new home.

When their hopes are dashed

Many of these children come to relatives whom they do not know. And expectations and fantasies that the children have developed in anticipation of the family life they hope for may bring disappointment. The relative, on his part, may also be disappointed in the newly arrived child. An aunt or a cousin may resent the fact that the child, unhappy as a result of his disappointment, is unresponsive, ungrateful, and uncooperative. The child then feels that he is misunderstood. Because he has recently experienced shock, violence, and uprooting, he especially needs a family; he needs to belong to a home. His need may express itself in an apparently unreasonable demand for the complete love and attention of the person who made his coming possible. This person usually is a woman, who is taking the place of his lost mother.

One boy, 15 years old, who came alone because he was the only survivor of his family, was taken to the home of an aunt who had several children of her own. The aunt, a warm, understanding woman, made every effort to make him feel part of the family. But the boy had such an intense need for attention and affection that he resented having to share his newly found "mother" with her own children; and his resentment made him behave in an undesirable way. He sought attention outside the home, and on his own initiative found just what he needed — a satisfactory mother substitute in a neighbor, a childless woman who became very fond of him. She gave him undivided attention, so that his intense needs were met. Staff members of the agency that was interested in his adjustment studied the situation carefully and decided that a change of homes would be helpful to him. And so they arranged for him to be placed for foster care in the home of the neighbor with whom he got along so well.

As with other immigrants, social aspects of immigration and of becoming part of a different culture create problems for displaced persons. Children as a rule become part of the new society more easily than their parents do. Often a conflict arises between parents and children because the mother and father retain the customs of the "old country," and the youngsters want to follow the ways of those with whom they play and go to school or to work.

These problems of adjustment between the older and younger generations are about the same whether the immigrants came before World War I or after World War II. In spite of the excellent work done through the years by various agencies developed to help the immigrant, their services cannot reach all those who need such services. The agencies help some families and individuals at the beginning of their difficulties, when it

is relatively easier to solve their legal and economic problems and to prevent problems from developing.

The parents in a displaced family, recently arrived, came to our agency for help with their 14-year-old son; they were much disturbed about him. He refused to obey them, threatened to leave home, and began to stay away from school.

When our worker came to understand the family situation, she realized that the boy resented the fact that his friends in school were allowed privileges that he did not have. His parents pointed out that boys in the old country did not have these privileges.

For mutual understanding

Our worker was able to help the parents understand what activities 14-year-old boys in this country take for granted and are allowed to carry on. At the same time, she helped the boy to understand why his parents could not follow so easily as he did the customs of the new society and therefore did not think them suitable for him. In a comparatively short time the relations between the boy and his mother and father improved and also the boy's attitude toward school, and with it his attendance.

A widow and her two little boys went through a similar difficulty. The husband and father had been killed by the Nazis. The mother escaped death by fleeing from their home with her two baby sons and hiding in the woods. There, in the open, they managed to keep alive for several years under unbelievably hard conditions. The mother even managed to teach the two little boys to shake their heads instead of crying, for the three had to be very quiet; an outcry from the children might mean capture and death.

Miraculously, the mother and children lived through their ordeal and finally reached the United States. The boys were 6 and 8 years of age and the mother 41 when they came to the agency. The mother, timid and frightened, was completely confused by the new conditions of life. She had not made friends and was not trying to learn the new language that she needed so much.

Little Hannelore and her parents arrived in the United States about 6 months ago. They were sponsored by the director of a religious organization, and are now living on a farm.

The children, meanwhile, were adopting the ways of their new country very quickly; they were soon able to express themselves almost entirely in English. They made friends in their neighborhood and became preoccupied with them, wanting to be out of the house much of the time. The mother feared that her sons were becoming estranged from her because of their new interests. She sought the worker's help in holding her children close to her. The worker encouraged her to change her attitude toward the new surroundings and to take an active part in it by learning English and making friends. That would help her to keep pace with her children's adaptation to their new home and to break with the sad memories of the past.

The mother discovered in herself the adaptability she needed, and she began to take advantage of the worker's help and to use it. She came to appreciate the value of her sons' new friendships and to try to follow their lead in entering more fully into neighborhood life.

The struggle of the immigrant breadwinner to find his place in the economic structure here affects the children in the family as intensely as the struggle between Old-World and New-World customs. Vocationally, immigrant workers are a minority group—like others against whom prejudice is directed. They are quickly affected by any downward trend in the labor market.

Most of these newcomers who are the heads of families expect to become wage earners as soon as they arrive; failure may make these parents feel inadequate. If the difficulty is marked enough, it may affect the children's feelings about their father's role in the family. These discouraged immigrants may fear that a community that is helping to support them may begin to disapprove of them, expecting them to become independent quickly.

ROSE E. DRAPKIN has based this article on a paper that she gave at the seventy-sixth annual meeting of the National Conference of Social Work. At the time she wrote the paper Miss Drapkin was Director of the Family Service Department of United Service for New Americans; this department is now part of the New York [City] Association for New Americans.

Our agency receives quite a few letters complaining about displaced persons' receiving relief, and hinting that the d. p.'s have undisclosed financial resources. Usually these complaints are unfounded. Quite commonly the letter writers say that *they* came here years ago as immigrants and made their way successfully without assistance.

Helping the community understand the conditions from which the displaced persons come and the need of some of them for assistance is an exceedingly important part of our work for these people.

Parents and children in immigrant families have to make other major adjustments to social institutions in the United States—to schools, to recreational services, to hospitals, to adult-education classes, and to offices of various kinds. For some families, using these strange services brings on anxiety. Other families coming into contact with the services build up aims that are unreachable. The urge to make up for lost years may express itself in a drive to achieve results that are beyond their own potentialities to achieve or beyond the limits of our agency's policy to help them with.

They break with their past

Immigration is a distinctly personal experience to the newcomer as well as an experience that may have legal, social, and economic complications. It affects children greatly because their feelings of security depend so much on their belief that their parents feel safe and secure. To many parents the radical changes brought about by immigration mean losing the old sources of personal support such as past associations, the customs of many generations of their ancestors, their own language as the common means of communication. And they find that new sources of such support are not easily found.

How are we answering the questions: What kind of help does the immigrant family need? What kind of help will benefit the parents and children and, because it helps them find their places among other parents and children, will benefit the community also?

Our planning of such a program of services must be affected by a number of limiting factors.

First, services to immigrant families are bound to be costly because these families have many needs that cost money to fulfill—a place to live, furniture, clothing, medical, dental care, vocational training. Inadequate financing is the main limiting factor. Community attitudes come into this because on these attitudes depends the amount of financial support.

Second in seriousness is that the demands on the service cannot be controlled by the agency. A sudden influx of immigrants strains the staff and the physical facilities of the agency. The staff cannot be enlarged easily to meet these temporary requirements because the number of case workers experienced in serving immigrants is limited. This shortage of specialized case workers makes it difficult even to get an adequate staff of qualified case workers for a normal amount of service between peaks of arrival. The workers cannot serve a large number of clients at one time because the work with each family is intensive.

The movement of peoples from one country to another has been accepted in history as a normal process. A difference between the early and the current immigration to this country is that the earlier immigrant usually came by choice, but the later immigrant was forcibly set adrift from his moorings.

The choice of the early immigrant sometimes was made reluctantly, as a result of hardships—religious, economic, social, political—but it was a choice freely made. The refugee families who left Germany during the rise of Hitler's power had some element of choice in their going. Foreseeing events to come, they were able to escape the unspeakable experience of slave labor and concentration camps, the constant threat of extermination, or death itself. They could keep their families together and save enough to start afresh in a different country.

A new group of immigrants

The second wave of immigration, caused by World War II, stands in vivid contrast to the previous one. The individuals and families were survivors of concentration camps and camps for persons taken from their homes for slave labor or other reasons connected with the war. They were admitted to this country beginning with 1946 under a directive issued by President Truman, and later under the Displaced Persons Act. There is no need for me to dwell on the facts of their suffering, already well known

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Waiting to go to America, displaced persons may build higher hopes than can be fulfilled.

YOUTH AND ADULTS IN 50-50 PARTNERSHIP

Join in planning and carrying out community activities

MRS. HIRAM COLE HOUGHTON

IN NEARLY 3,000 cities and towns all over the United States, young people and adults are jointly planning and carrying out community activities as part of a program sponsored by the General Federation of Women's Clubs.

The Federation launched its program of youth-adult partnership on December 7, 1950, the same day that the Midcentury White House Conference recommended "that progressive opportunities should be provided for young people to participate vitally in community activities and planning in order that they may have early preparation and experience for leadership and community service. . . ."

As a step toward providing such opportunities to youth, the Federation invited each of its member clubs to set up a project on which adults and youth would share responsibility in meeting one or more community needs.

"Build Freedom With Youth" the program was named because the Federation believes that giving young people a chance to work with adults for their community is one way of helping them learn to cherish the freedom of our way of life.

In the past we have all seen many projects for community betterment in which youth took part. Most such projects are led by adults; they take full responsibility; and the boys and girls who take part are only allowed to be helpers. In the General Federation projects, on the other hand, the young people share the responsibility with the adults—not only for carrying out the project, but for planning it.

The value of a community project as a means of youth development, according to our criteria, is determined by (1) the extent of youth participation, (2) the importance of the project to the community welfare, and (3) the number of adult groups and individuals that cooperate.

And what are the projects like?

In Waldo, Ark., the young people voted that they most wanted to get rid of the dust in their town. And they campaigned for private contributions that paid for paving the streets. Afterward they joined with the grown-ups in cleaning the town, even the vacant lots. The young people obtained seedling pines from the Soil Conservation office, and every school child—as well as many adults—planted his own tree, which bears his name.

The youth-adult partners also set up a library, using as a library building a store that was offered by its owner for that purpose.

Everybody joined in building shelves, painting them, putting up books (borrowed from the county library through bookmobile service), and soliciting additional books from the townspeople.

At the Midcentury White House Conference on Children and Youth, held in December 1950, about 500 young delegates like these joined in adopting a resolution urging that youth should be provided with opportunities "to participate vitally in community activities and planning."

Now members of the youth-adult group serve as volunteer librarians and they take books and magazines to hospital patients and to shut-ins.

These are only a few of the activities through which the adults and young people of Waldo are benefiting the community.

Adults and young people together made a survey of the needs of their community, Panama City, Fla. They worked out a city-wide recreation and

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MRS. HIRAM COLE HOUGHTON is President of the General Federation of Women's Clubs, which has an international membership of some ten million women. Mrs. Houghton is a graduate of Wellesley College, and she has been granted two honorary degrees: Doctor of Laws (Coe College, Iowa) and Doctor of Humanities (Tarkio College, Mo.). She is a vice president of the National Society for Crippled Children and Adults, Inc.

AGGRESSIVE CHILD

(Continued from page 149)

are to take place at all! Hence, the very small child cannot reach out, attack, and possess or express the new habit, the new word, the new game unless he is so secure in his relationship with his parents that he does not feel it necessary to cling to and repeat endlessly the same responses day after day.

It seems, too, in clinical and educational work with some older children who, though they may have superior intelligence, are blocked educationally —it seems as if their passivity and inertia were due to a recurrent feeling of insecurity that did not allow them to put forth the aggression (on our report cards we call it "Effort") required in learning new things. As I have said, this relationship between aggression and learning has not yet been explored to the point where we can tell exactly what is going on, but we see enough to know that it is an important relationship.

Three guides offered

Perhaps I have outlined sufficiently the problems that you and I face when we are confronted by an aggressive child. At least I hope that the complexity of this problem in any child is clear. Presumably we would like to have some definite hard and fast rules for dealing with the aggressive child, but unfortunately we do not have them. However, I can cite three general rules:

1. In the first place, the individual aggressive child must be studied carefully by the parent to see if it is possible to find out what the aggression means to the child himself—to get at what unexpressed purpose it is serving. Such meanings in their subtleties will vary with the child, and it will tax your ingenuity to determine what they are. However, a discovery of the possible true meaning places you more than halfway toward application of a successful treatment.

2. Neither planned rigidity nor planned freedom of expression will solve the problem of the aggressive child. In other words, you can't just stamp out aggressive tendencies by rigid repression and repeated punishments—nor can you expect that freedom from all restraint, and license to express aggression whenever the child wishes, will make for cessation of such acts. Both general plans will merely bring on more aggressive acts.

3. An excellent rule to follow in the presence of the aggressive child is not to respond to the child's aggression with aggression on your part. Aggression (or the threat of it) begets aggression.

Finally, I would not be doing my duty as a psychiatrist if I did not cite for your help the types of expression of aggression that should suggest that the child needs psychiatric help.

(a) A child should not be allowed to express aggression in acts that are harmful to the body of another youngster. I mean by this not occasional scraps or fist fights and shovings around, but deliberate, unprovoked infliction of pain through mutilative acts, cutting, scraping, the use of sharp sticks, and so forth. A child who persists in such acts should be seen by a psychiatrist.

(b) Children (I am speaking of boys here) who persist in harmful aggressive acts against persons or animals up to and into the adolescent years — that is, to 13 years — need psychiatric help. Inability to gain control of the mutilative destructive aspects of aggression in the early years can make for serious trouble if it becomes linked to the expression of the sexual drive in adolescence.

Most parents succeed

In conclusion, I am happy to say that, fortunately for all of us, 99 percent or more of children pass through the various developmental phases in the control of their aggressive instincts without trouble, and they arrive at adulthood with fairly numerous, diverse, and socially worth-while means of expressing these instincts. In spite of all you hear to the contrary, it seems to me that this fact speaks well for the good intentions, the hard work, and the great skill of the parents who do this grand job of child care!

Reprints in about 6 weeks

DISPLACED FAMILIES

(Continued from page 153)

—nor the effect of violence and indignity on them as persons. I should like to stress instead the fact that so many of them, with or without help, have been able to marshal their native resourcefulness and make a good adjustment to new surroundings. But I must speak of the many others whose identification with the past cannot be broken and who need intensive help in order to make even a minimum adjustment.

These clients, when they seek our assistance, present many needs, some immediate and some future. The head of a family is as much concerned about the problems of his home life as he is about whether he can get and hold a job in order to fulfill his responsibility as the chief breadwinner.

We help him to take his share of responsibility for stating his need and his eligibility for help. Gradually he learns to exercise again his capacity for making decisions; even to express his own choice, without fear. He begins to lose his dread of taking help, at least with the difficulties in his situation that he cannot handle alone.

Agency fosters clients' self-confidence

The client and the worker come to an agreement that the client needs the service of the agency and that he will work with the agency on his need with a clearly understood purpose and in accordance with the policy of the agency and the services we make available. After that the worker helps him focus on a continuing contact with the agency as long as he needs it.

Many native-born Americans (even those whose immediate forebears came to this country as immigrants) think that the immigrant families of today should be given only a preliminary kind of help, perhaps as the ship docks, and that afterward the families can take care of themselves, in spite of the rush of bewildering events, many of which turn out wrong because the newcomers misunderstand them. Some of those who dis-

believe in immigration services may have arrived at this conviction after careful thought, and others may be forced into this conclusion by the limiting factors I have mentioned—the lack of funds to support all the services that seem desirable or the lack of qualified social case workers that makes a rationing of them necessary.

I, myself, am convinced that it is highly desirable for communities to help immigrant families make a good adjustment to their new surroundings. We know what uprooting can mean and why these families have been uprooted. And when we open our gates to allow the families to come here we take on a responsibility as a people to make them know of our desire to help them find normal living here.

In every phase of social work we are emphasizing more and more the preventive aspects of mental hygiene. I can think of no better service to emphasize it in than work for newly arrived families whose lives have been filled with the terrors that may wreck the human spirit; who have withstood such terrific hardships that a new onslaught of difficulties, though of lesser degree, may be the last straw. Unfortunately, little of our knowledge of preventive mental hygiene, of how to strengthen mental and emotional health, has yet been applied to the field of immigration service. Communities could profit financially and in the preservation of human resources by investing in such a program.

In presenting the difficulties that confront displaced families on their arrival here, and the factors that limit the kind of program we set up to help them, I do not wish to imply that the obstacles to success are unsurmountable. I want, instead, to show that we must understand these difficulties if we are to prevent them or to deal with them after they have happened. Today's immigrants to our shores have an amazing reservoir of strength and an unusual drive to achieve the life they want for themselves and their children.

Reprints in about 6 weeks

RESEARCH

(Continued from page 150)

tions that are engaged in research on children.

The scope of the research that has been reported is indicated in the table of contents. The projects are classified under six headings. These are: Behavior and Personality, Educational Process, Growth and Development, Physical Health and Disease, Pregnancy and the Perinatal [before, during, and after birth] Period, and Social, Economic, and Cultural Factors. Specific subjects are indexed alphabetically.

To continue reporting

The Clearinghouse plans to prepare, periodically, additional bulletins and supplements, based on up-to-date reports from investigators whose studies have been inventoried in the past and from new investigators who undertake research. We hope to increase the coverage continually and to increase the usefulness of the inventories by making more stringent the requirements for inclusion.

Cooperation encouraged

From the information reported on the projects, investigators may gain perspective on their own work. Also, as a result of the knowledge that they gain from the inventories about the studies being made by other workers, they may wish to communicate with one another directly to exchange ideas relating to their own research problems. Through this exchange of ideas we in the Children's Bureau expect an increase in cooperative planning and in multidisciplinary research.

One of the major objectives of the inventories is to stimulate research in areas of knowledge that have been neglected. To the Children's Bureau and to others interested in sponsoring or carrying out research concerning children, these inventories provide a basis for determining areas in which further research is needed.

In an effort to encourage interchange of ideas among research workers, the Clearinghouse is considering the feasibility of sponsoring small conferences of active research workers in very specific areas of interest. These conferences may serve any of several purposes: Exchange of information, clarification of concepts, analysis of research needed—whatever is most valuable at a given time to foster research in the area of child life.

We seek fresh ideas

The policy of the Clearinghouse is made with the help of an advisory committee of six consultants from a variety of fields. Membership rotates so that new ideas will continue to be presented.

The members of the committee at this time are:

Dr. John E. Anderson
Director
Institute of Child Welfare
University of Minnesota
Minneapolis 14, Minn.

Dr. Ernest W. Burgess
Department of Sociology
University of Chicago
Chicago 37, Ill.

Mr. David G. French
Assistant Executive Secretary
American Association of Social Workers
1 Park Avenue
New York 16, N. Y.

Dr. Willard C. Olson
Director of Research in Child Development
University Elementary School
University of Michigan
Ann Arbor, Mich.

Dr. John W. M. Whiting
Laboratory of Human Development
Graduate School of Education
Harvard University
Cambridge, Mass.

Dr. Irving J. Wolman
The Children's Hospital of Philadelphia
Philadelphia 46, Pa.

50-50 PARTNERSHIP

(Continued from page 154)

improvement plan, and helped to get a bond issue to pay for it. The plan provided for a waterfront amphitheater, a stadium, parks, and playgrounds.

Again in Florida, 850 Negro students in Fort Pierce worked with adults in three shifts — morning, noon, and night—to clear a site for a Negro community center. In order to obtain the $20,000 needed to build the center, young people and adults, both Negro and white, are holding benefits, playing ball games, and passing the hat.

In Bellows Falls, Vt., and in Acworth, N. H., boys and girls canned surplus foods during the summer for the school-lunch program. Acworth young people also raised funds for a school kitchen.

Last year, every Saturday afternoon from spring until snow, both young people and adults in Balsam Lake, Wis., worked on clearing a beach, digging out roots, carrying rock for a wall, and building the wall.

In Billings, Mont., youngsters helped adults raise $5,000 for a receiving home for children, so as to do away with putting them in jail, and are continuing to raise money to carry it on.

Boys and girls in York, Me., joined with older people in turning an unused railroad depot into a recreation center. They have held dances and dancing classes in the center, and, with the help of a preacher, they have held an 18-week course in recreation leadership for 50 people—adults and youth.

Think of nearly 3,000 similar projects in the various cities and towns of the United States, and you will get an idea of how well American young people are responding when they are called on to take responsibility.

The clubs reporting tell us that their reports are not final ones, for the projects are only the beginning of long-term plans for community self-help in which adults and youth will continue to join in partnership.

• FOR YOUR BOOKSHELF

SO YOU WANT TO ADOPT A BABY. By Ruth Carson. Public Affairs Pamphlet No. 173. Public Affairs Committee, Inc., 22 East Thirty-eighth Street, New York 16, N. Y., 1951. 32 pp. 20 cents.

"Why the baby shortage?" "What's the matter with the agencies?" "Is red tape the trouble?" These and some other questions that are asked by couples who would like to adopt a baby are answered in this pamphlet.

The author describes the place of the social agency in adoption, the protection it provides to both adoptive parents and child, and the dangers involved in taking a child without such protection. She explains why not all of "those children in institutions and foster homes" are free for adoption. For one thing, she points out, three-quarters of them are more than 6 years old, and these could not relieve the shortage of babies. And most of these older children are only temporarily away from home; nearly all have one or both parents living.

The pamphlet clears up many of the misapprehensions that cause unsound criticism of the work of adoption agencies.

I. Evelyn Smith

THE FOOD STUDY; Analyses of the Unit Cost and Nutritional Adequacy of Feeding in Thirteen Los Angeles Community Chest Children's Agencies. Prepared by Ernest Greenwood. Publication No. 10. Research Department, Welfare Council of Metropolitan Los Angeles. 1951. 80 pp. $1.50.

This study was undertaken to supply information needed by the General Budget Committee of the Community Chest in reviewing the estimated costs of food in the children's institutions served by the Chest. The committee wished to know the range of costs of feeding children in the various institutions and whether the differences in costs were related to differences in nutritional adequacy.

The method for the study was adapted from the procedures in use for some years by the California Youth Authority. The findings were expressed in terms of the pounds of each of 20 food groups available through purchase, donation, or home production in each of the 13 institutions and 3 day nurseries included in the study. The nutrients available per capita were calculated according to a short method and, after estimated losses in cooking had been applied in the case of certain vitamins, these nutrients were compared with the appropriate "recommended daily allowances" of the National Research Council.

Costs per child per day showed a wide variation, the highest being twice as much as the lowest. Although the institution spending the least for food did not make a favorable showing as to nutritional adequacy, some of those in the middle range provided more nutritious food than those with the highest food expenditures. Inasmuch as no attempt was made to calculate waste, there is no assurance that the food available was actually consumed by the children. Such a study, therefore, may have more meaning for budgeters than for nutritionists and other child-health workers.

Marjorie M. Heseltine

WHY CHILDREN MISBEHAVE. One of a series of Better Living Booklets. By Charles W. Leonard, Superintendent, Illinois State Training School for Boys, St. Charles, Ill. Science Research Associates, 57 West Grand Avenue, Chicago 10, Ill., 1952. 49 pp. Single copies 40 cents; three for $1.

"How can we handle the normal everyday misbehavior of children? How can we keep it from being serious?"

These two questions, posed on the cover of this booklet, set the reassuring tone that permeates every page of what should prove a real help to anyone who deals with any children. Once we have accepted the author's statement that "misbehavior is a normal part of the growing up process," the air is cleared of a lot of gloomy foreboding. Now we can get down to the business of trying to understand how we unwittingly set the stage for misbehavior, how different people react to and judge children's actions, and under what circumstances misbehavior becomes serious. How parents and teachers can detect, in frequent or intense misbehavior, indications of a child's emotional difficulties is suggested in one of the most significant sections of the pamphlet.

If we are unable to understand a child, or to accept his feelings; if we

impose our own hostilities on him; if we are too much concerned with "what other people will think," or if we are convinced that our way is the right and only way; then, the author says, we need to stop and ask ourselves a number of questions. Taking a good look at ourselves will often enable us to take a more constructive view of our children's behavior as a whole, and be stimulated by the satisfying, if tremendously challenging, nature of our job.

The author's wide experience, not only as superintendent of a school for delinquents but as a former director of a psychiatric child-guidance clinic, shows up in his recognition that *all* children would have a better chance for emotional health if adults added to their insight and sensitivity.

Marion L. Faegre

AN EMPLOYMENT SURVEY OF 4,014 TEXAS SCHOOL CHILDREN. By Lazelle D. Alway. National Child Labor Committee, 419 Fourth Avenue, New York 16, N. Y. Publication No. 404, November 1950. 24 pp. 50 cents.

This is an excellent presentation of the results of a study made by the National Child Labor Committee in conjunction with a study of Spanish-speaking people made by the University of Texas. Highlights of the findings are vividly shown through an imaginative use of graphic techniques.

Although the study was limited to selected cities in Texas, the findings are nonetheless valuable in helping communities in other areas to understand and meet the needs of young people who combine school with work. The report can do much to focus attention upon an aspect of youth employment that will come more and more into the limelight if recent upward trends in part-time employment of young people of high-school age continue.

Elizabeth S. Johnson

IN THE NEWS

Medical social work. Scholarships in medical social work, for second-year or third-year study at the University of Chicago's School of Social-Service Administration, are offered by the University of Illinois, Division of Services for Crippled Children, through funds from the Children's Bureau of the Federal Security Agency.

The scholarships are available to applicants who have satisfactorily completed one year of graduate study in an accredited school of social work, who have had successful experience in case work and are interested in entering the field of public health or in teaching medical social work. The field-work placement is carried on in the University of Illinois, Chicago office of the Division of Services for Crippled Children.

Applications should be made immediately to the Dean of the School of Social - Service Administration, University of Chicago, Chicago 37, Ill.

Congenital heart disease. A special grant to aid children with congenital heart conditions in 12 Midwestern States has recently been made by the Children's Bureau.

"Blue babies" and other children with congenital heart defects that can be helped by surgery will have the chance to be operated on by experts. The highly specialized and technical services necessary for the diagnosis and treatment will be provided to children with such defects, for whom the services are not available locally.

Dr. Herbert R. Kobes, Director of the Division of Services for Crippled Children, of the University of Illinois, has completed plans for the program. The children will be hospitalized at Children's Memorial Hospital in Chicago, which is one of the country's outstanding institutions in this field of cardio-vascular surgery and where about 500 such operations have been done during the past few years. They will be under the care and supervision of doctors who are nationally recognized specialists in congenital heart disease.

This is the third in a network of such services in the country. Already in operation are regional programs for children with congenital heart defects in Connecticut and California. The Connecticut program offers services to children in some of the New England States. The California program serves children in Arizona, Idaho, Nevada, Alaska, and Hawaii.

Children in Illinois with serious heart conditions already have access to service under the State crippled children's program. Children who will be cared for under the new program may come from surrounding States, including Michigan, Ohio, Kentucky, Minnesota, Wisconsin, Indiana, North Dakota, South Dakota, Nebraska, Iowa, Kansas, and Missouri.

A total of $100,000 a year of Federal funds has been earmarked for financing the cost of care given children at the regional heart centers. None of this money goes directly to families. All of it is paid to State crippled children's agencies, under whose sponsorship children requiring care are sent to the heart centers.

Preliminary estimates are that surgical and hospital care and related services will cost on the average $1,000 for each child treated. This will permit caring for about 100 children each year throughout the country.

For full geographic coverage of the entire country, studies are being made of the best locations for other programs.

Art. School children in nearly 20 countries now have a more vivid idea of how people in other countries live, as a result of an international school art program now entering its fourth year in the United States.

The program, sponsored by the American Junior Red Cross, began in 1947, when pupils in the United States and Canada sent 3,000 drawings, depicting life in their countries as they see it, to other nations. By 1950, more than 1,800 schools in the United States and Canada had submitted work to the program.

Some of the countries that have received children's art from North America through the Red Cross are Australia, Belgium, Czechoslovakia, Iran, Japan, Venezuela, and Yugoslavia. Recently, the program has begun to work in both directions, with 10 countries sending examples of their own children's art.

Fellowships offering specialized training in child psychiatry are available in a number of member clinics of the American Association of Psychiatric Clinics for Children, which have been approved as training centers by the Association. The training begins at a third-year, post-graduate level. Minimum prerequisites are graduation from medical school, a general or rotating internship, and a 2-year residency in psychiatry—all approved. The majority of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

This training is in preparation for specialization in child psychiatry, and

especially for positions in community clinics devoted wholly or in part to the out-patient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction in therapeutic techniques with children in out-patient settings which utilize the integrated services of the psychiatric clinic team. Most of the clinics have a 2-year training period although a few will consider giving 1-year training in special cases.

The office of the American Association of Psychiatric Clinics for Children acts as a clearing house for applicants. Application may be made through that office or directly to the individual clinics. In all cases acceptance of applicants for training is by the individual training centers.

For further information and for application forms, write to Mary C. Bentley, Executive Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, N. Y.

Child labor. Of 3,465 children under 16 found by Department of Labor investigators to be employed in agriculture during school hours, two-thirds were less than 14 years of age, and 15 percent were from 5 to 9 years. The investigations were made during the year ended June 30, 1951, by the Department's Wage and Hour and Public Contracts Divisions, which are responsible for enforcing the Fair Labor Standards Act of 1938. This act, as amended in 1949, sets the minimum age for employment on farms during school hours at 16 years.

The reports on the investigations do not describe conditions on all farms in the United States, nor cover all the children who work on farms. But investigations were made in States where acreage warranted it, in crops that traditionally employ children.

Reprints of an article reporting details of these findings are available on request from the Wage and Hour and Public Contracts Divisions, U. S. Department of Labor, Washington 25, D. C.

Summer Courses

Smith College. School for Social Work. Northampton, Mass.

Graduate seminars for experienced social workers: Advanced case work, supervisory methods in social case work, ego psychology, and case-work interpretation and writing (July 7 to 17).

Advanced study for experienced graduate case workers preparing for positions of increased responsibility and leadership. Individual programs are arranged according to the qualifications and ultimate objectives of each student (July 23, 1952, to July 29, 1953).

Candidates may be admitted for the 1952 summer session only (July 23 to August 27).

University of Denver. School of Social Work. Denver, Colo.

Workshops: Dependency and allied problems in social work; Case work with ill and handicapped people; Developing skill in supervision; and The group-work method in social work (August 18 to 22).

University of Washington. Graduate School of Social Work. Seattle 5.

Seminar in social work with children: Child-welfare case work studied in light of emotional needs of children; how foster homes and/or institutional placements help or hinder emotional development of children. Term A (June 23 to July 23).

Seminar in supervision. Term B (July 24 to August 22).

Additional courses also available.

Western Reserve University. School of Applied Social Sciences, Cleveland 6, Ohio.

Institute on intercultural and interracial relations in group work (June 13 to 16).

The third annual Marriage and Family Life Study Tour, sponsored by the National Council on Family Relations, will be held this summer. This seminar will study family life in Sweden, Finland, Denmark, Holland, France, and England.

A group of 20 selected people will sail from New York July 8 and return there September 2. Academic credit will be available from the State University of New York or Florida State University. Write to the director, Eugene P. Link, State University of New York, New Paltz, N. Y.

Many other courses and workshops in family living will be offered this summer by colleges and universities. Some of these are: Community programs in marriage and family-life education (Florida State University); Workshop in family health, for secondary teachers (Kansas State College); Work conference on the problems of the family (Columbia University); Family-life education (Pennsylvania State College); Guidance and child behavior (Purdue University). Further information is published in recent issues of *Marriage and Family Living*, the quarterly journal of the National Council on Family Relations, 5757 South Drexel Avenue, Chicago 37, Ill.

CALENDAR

July 19 - 26. Eleventh International Dental Congress. London, England.

July 20 - 26. National Farm Safety Week. Ninth annual observance. Information from National Safety Council, 425 North Michigan Avenue, Chicago 11, Ill.

July 23 - Aug. 9. Eighteenth International Red Cross Conference. Toronto, Canada.

July 28 - Aug. 10. World Assembly of Youth. Fourth annual meeting of the Council. Dakar, Senegal, French West Africa.

Aug. 26 - 28. American Political Science Association. Forty-eighth annual meeting. Buffalo, N. Y.

Aug. 31-Sept. 2. National Council on Family Relations. New Brunswick, N. J.

Regional conferences, American Public Welfare Association:

Aug. 20-22. Mountain region. Cheyenne, Wyo.

Sept. 2-4. West Coast region. Victoria, B. C., Canada.

Oct. 9-11. Northeast region. Philadelphia, Pa.

Oct. 23 - 25. Southeast region. Charleston, W. Va.

Regional conferences, Child Welfare League of America:

Sept. 25-27. Midwest region. Des Moines, Iowa.

Illustrations:

Cover, Massie for Missouri Resources Division.

Page 146, Philip Bonn for Children's Bureau.

Page 148, Esther Bubley for Children's Bureau.

Page 153, UNRRA photograph.

Page 154, Archie L. Hardy for Children's Bureau.

THE CHILD

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Published 10 times a year by the Division of Reports, Children's Bureau
Editor, Sarah L. Doran Art Editor, Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others the subscription price is $1.25 a year. On all orders of 100 or more sent to one address there is a discount of 25 percent. Send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies 15 cents each.

Foreign postage—25 cents additional—must be paid on all subscriptions to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

REPRINTS AVAILABLE

A limited number of copies of the following reprints from **The Child** are available for distribution. Single copies may be had without charge until the supply is exhausted.

A Proposal for Joint Action Against Congenital Syphilis. By Betty Huse, M.D., and W. H. Aufranc, M.D.

Psychologist Can Help in Planning for Baby's Adoption. By Helen Rome Marsh.

A Rural Community Plans for Guidance of Its Boys and Girls. By Amber Arthun Warburton.

Saving Epileptic Children. By William G. Lennox, M.D.

Schools Are a Fertile Field for Mental-Health Efforts. By Benjamin M. Spock, M.D.

So That Children Can Hear Better. By William G. Hardy and Miriam D. Pauls.

Stop Sniping at Parents. By Samuel Whitman.

To Combat Cerebral Palsy. By Donald J. Bourg, M.D.

To Restore Crippled Children. By Edwin F. Daily, M.D.

To Synchronize the Training-School Program With Life in the Community. By Richard Clendenen.

Teamwork in Texas. By Katherine Glover.

Toward the Future; 15 Years of Progress in Maternal and Child Health. By Edwin F. Daily, M.D.

We Organize a Clearinghouse for Research in Child Life. By Clara E. Councell.

West Virginia Sets Up a County Demonstration Program for Saving Premature Babies. By Hallie Isabel Morgan.

What Are the Trends in Child-Guidance Clinics? By J. Franklin Robinson, M.D.

What the Birth Record Means for a Child. By Helen C. Huffman.

What Health Services Do School-Age Children Need? By Thomas E. Shaffer, M.D.

When a Baby Dies Unexpectedly. By Katherine Bain, M.D.

When a Community Plans for Mental Health. By George S. Stevenson, M.D.

Workshops of Wonder. By Katherine Glover.

To Our Readers—

We welcome comments and suggestions about **The Child.**

U. S. GOVERNMENT PRINTING OFFICE: 1951--912044